

**ATTENDING PHYSICIAN STATEMENT
FMLA CERTIFICATION FORM
ALEXANDER CITY SCHOOL SYSTEM
ALEXANDER CITY, ALABAMA**

Please complete the following information:

Employee's Name _____ **SSN:** _____

Name of injured/ill person (if other than employee): _____

Description of current injury/illness: _____

Physician's recommendation: _____

Date individual first seen by physician for this injury/illness: _____

Estimated length of absence from work in days: _____

I certify that the information above concerning the named employee of the Alexander City Board of Education is correct.

Please type or print physician's name and address:

Signature of Attending Physician