

**LOCAL EDUCATION AGENCY  
PHYSICIAN CERTIFICATION FORM**

<b>1. Name of Injured Employee (Please type or print)</b> (Last) (First) (MI)		<b>2. Social Security Number</b> _____-_____-_____	<b>3. Date of Birth</b> ____/____/____	<b>4. Sex</b> ___ M ___ F
<b>5. Home Address</b> (Number and Street) (City or Town) (State) (Zip)		<b>6. Telephone Number</b> Home ( ) Work ( )	<b>7. Job Title</b>	<b>8. Status</b> ___ Full Time ___ Part Time ___ Contract
<b>9. Employing Agency</b>		<b>10. Agency Address</b> (Number and Street) (City or Town) (State) (Zip)		
<b>11. Date of Injury</b> ____/____/____	<b>12. Is there a reasonable expectation that the employee will be able to return to work?</b> ___ Yes ___ No		<b>13. If "yes" on item 12, give the date or approximate date of return.</b> ____/____/____	
<b>14. If the employee can return to work, are there any restrictions on the employee's duties? If so, how long will the restrictions apply?</b>				
<b>15. If "no" on item 12, give details for employee not being able to return to work.</b>				
<b>16.</b>				
_____ <b>Signature of Attending Physician</b>		_____ <b>Print Name</b>		_____ <b>Telephone Number</b>
				_____ <b>Date</b>