

MADISON COUNTY SCHOOLS

**MEDICAL VERIFICATION
FAMILY AND MEDICAL LEAVE or CATASTROPHIC ILLNESS/INJURY**

*To be completed by a physician and submitted with the appropriate leave request
when requesting either Family and Medical Leave or Catastrophic Leave*

Please supply all requested information. Attach additional sheets if more space is needed to fully explain condition.

NAME OF EMPLOYEE _____ **SOCIAL SECURITY NUMBER** _____

WORK SITE _____ **POSITION** _____

Which type leave is employee requesting? Family and Medical Leave Catastrophic Leave

Date serious health condition or catastrophic illness/injury began: _____

Likely, or anticipated, duration of the condition, illness, or injury: _____

Appropriate medical facts within the knowledge of the physician to substantiate the serious medical condition or catastrophic illness/injury: (Attach additional sheets if more space is needed.)

If employee is to care for sick spouse, child, or parent, state conditions/reasons why employee must care for this person: _____

Due to the employee's health condition, and your understanding of the employee's job functions, is this employee able to perform the essential functions of the job? YES NO

If NO, can he/she do so with accommodations? YES NO

If YES, suggested accommodations: _____

Name of Physician (Typed or Printed)

Office Phone Number

Office Mailing Address

City, State, Zip

By my signature I verify the employee named above is incapacitated due to the health condition, illness, or injury described above, and thereby unable to perform his/her job during the stated time period.

Signature of Health Care Provider (No Stamps, please)

Date