# PHYSICIAN CERTIFICATION FORM

*ATTENTION: THE ATTENDING PHYSICIAN **MUST** COMPLETE THIS FORM IN FULL*

**Alabama Public Schools are not eligible for Workmen's Compensation and require this form to be completed for Employee Reimbursement with the Alabama Board of Adjustment**

**1. NAME OF INJURED** (Please Print/Type)

_____ _____ _____ M / F

First Middle Initial Last Social Security Number Date of Birth Gender (pls. circle)

**2. HOME ADDRESS**

_____ _____ _____ _____

Number & Street City State Zip Home Phone Work Phone Cell Phone

**3. Employing Agency – Homewood City Schools, 450 Dale Avenue, Homewood, AL 35209**

**4. DATE of INJURY: _____**

**5.** Is there a reasonable expectation that the employee will be able to return to work? ____ Yes ____ No

If **YES**, please give date or approximate date of return _____

If the employee can return to work, are there any restrictions on the employee's duties and length of time the restrictions apply? _____

If **NO**, give details for employee not being able to return to work. _____

_____

Is the attending physician referring this employee to another physician or medical agency? ____ Yes ____ No

If **YES**, name the physician or medical agency of the referral.

_____

Signature of Attending Physician Print Name Telephone Number Date

Name of Medical Facility and Address_____

**Attention Employee:** This form **MUST** be returned to the principal/supervisor if medical attention was required due to injury.



Revised: 10.10.24

# RETURN TO WORK
# MEDICAL EVALUATION FORM

NOTE TO PHYSICIAN: We need your assistance in protecting the health and wellbeing of the patient listed below. Your answers will help determine whether the employee needs to **1)** be away from work for further rehab and/or recovery, or **2)** if they could return – upon supervisor's agreement, on a restricted basis, or **3)** if they have been fully cleared by you and it has been determined they can resume their responsibilities with no restrictions or alterations to their work day and workplace, based on the job description provided. Please answer the following questions to the best of your knowledge.

**Name of Patient** _____

**Date of injury/surgery/onset of illness**_____ **Date of Exam** _____

**Diagnosis/description of injury/surgery/illness**_____

**The patient's return to work status is:**

___ Return to regular work. Effective _____

___ Able to return to work with noted restrictions. Effective _____

___ Unable to return to work until next evaluation, scheduled for _____

___ Referred to another health care provide for additional evaluations – please provide name of health care provider _____

**Lifting Restrictions:**

___ NONE ___ 10 –19 lbs ___ 20 – 29 lbs ___ 30 - 39 lbs ___ 40 – 50 lbs

**Follow-up Plan of Treatment:**

___ NONE
___ Return visit on _____ at _____ am/pm

Additional comments:

_____

_____

_____

Signature of physician Printed Name

Date

_____

Office Address Office Phone Number