Livingston Parish Public Schools

Mail Original to: LPPS/Human Resource Department
Post Office Box 1130
Livingston, Louisiana 70754-1130
Phone: 225-686-7044

LPPS Office Use Only
HR Approval __________
Other ________________

PHYSICIANS VERIFICATION FORM

(Complete top section before presenting to physician.)

EMPLOYEE #: ______________ **SOCIAL SECURITY #:** ________________________

NAME: ______________________________ ____________________________ ________
(Last Name) (First Name) (Middle Initial)

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned physician to release any information required in the course of my examination or treatment to Livingston Parish Public Schools.

__________________________________ __________________________________
Applicant's Signature Date

TO BE COMPLETED BY PHYSICIAN **Patient's Name** __________________________

Brief description of illness/condition in layman's terms:____
____
____

Is it <u>medically necessary</u> for the employee to be absent from work? ☐ YES ☐ NO

Per Louisiana R.S.17:1202, a catastrophic illness or injury is defined as a life-threatening, chronic, or incapacitating condition affecting an employee or a member of an employee's immediate family, as verified by a licensed physician. In your opinion, does the patient's medical condition qualify as a catastrophic illness or injury? ☐ YES ☐ NO

If this leave is for maternity, when is the *Estimated Delivery Date*? ______________________________
Month/Day/Year

Will delivery be by C-Section ☐ YES ☐ NO

Patient is under my care and unable to work from ____________________ to ______________________
Month/Day/Year – the first day missed **Month/Day/Year – the last day missed**

DATE PATIENT WILL BE ABLE TO RESUME FULL DUTIES: ______________________________
(THE LAST DAY MISSED CAN NOT BE THE RETURN TO WORK DAY) **Month/Day/Year – the day to return to work**

Physician's Name (*Please print*): _________________________ Office Phone #: ___________________

Office Address: ____
Street City State Zip

Subject to the provisions of Louisiana R.S.14:125, I hereby sign the sworn statement that the information provided above is true and correct.

Physician's Signature:

____ ______________________
Date

NOTE: A signature stamp is not acceptable and must be a physician's original signature.