ENTERPRISE CITY SCHOOLS
PHYSICIAN'S STATEMENT

Patient Name _____

Employee Name _____

School_____

Diagnosis: Nature and Extent of Disabilty _____

_____

Prognosis: _____

_____

Below is a continuum of services. Please check the one most appropriate:

____Unable to attend work (Please estimate length of time) _____

____Attend work/school full day	____WITH accommodations (List accommodations below)	____WITHOUT accommodations
____Attend work/school half day	____WITH accommodations (List accommodations below)	____WITHOUT accommodations

____Other (Please Specify):_____

LIST ACCOMMODATIONS: _____

_____

_____ _____

Signature of Examining Physician
(Must be original signature)

Date

_____

Printed Name of Examining Physician

_____

_____ _____

Address

Phone

Please complete and return this form to Enterprise City Schools; Attn: Delisa Bowman; PO Box 311790; Enterprise, AL 36331. Form is not valid without doctor's original signature and date. Telephone: (334) 347-9531

August 2011