



**Georgetown Independent School District
CATASTROPHIC LEAVE
ATTENDING PHYSICIAN'S STATEMENT**

Complete the Employee Information portion below. The attending physician must fully complete the remainder of the form. A request for catastrophic leave days will **not** be considered until the **Attending Physician's Statement** is received.

Employee Information:

Employee Name: _____ SS Number: _____
 Campus/Dept. _____ Date: _____
 Patient's Name: _____ Relationship to GISD Employee: _____

Attending Physician:

Please complete the following information regarding the patient named above.

Describe illness or injury in detailed, lay terms: _____

Date of diagnosis: _____

Is the patient's illness, injury, or condition life threatening? Yes _____ No _____

Name of Attending Physician: _____
 Address: _____
 Phone: (____) _____ Fax: _____

Explain the short-term prognosis: _____

Explain the long-term prognosis: _____

Dates of treatment: _____ Is patient still under your care? _____

Hospitalization:

Name and address of hospital: _____

 Date admitted: _____ Date discharged: _____ Is this condition due to pregnancy? _____

Answer Only if the Patient is a Georgetown ISD Employee:

As you understand this patient's job responsibilities, and based on your professional assessment of the patient's current condition, can you recommend this person to return to work at this time to perform his/her regular job assignment? Yes No

If the answer is no, what is the anticipated date of return to work? _____

I certify that the information given on this Attending Physician's Statement is accurate and true.

Physician's Signature: _____ Date: _____

**Please return the completed Attending Physician's Statement to:
 Georgetown ISD • Attn: Human Resources Department
 507 E University Ave • Georgetown, TX 78626 • Fax (512) 943-1894**

For HR Department Use Only

Yes No

Date Received _____