MONTGOMERY INDEPENDENT SCHOOL DISTRICT

District Advisory Committee

ATTENDING PHYSICIAN'S STATEMENT

Patient Information:

____ ________________________

Last Name First Name Middle Initial Social Security Number

School/Department:__________________________ Position:_____________________________

Authorization to Release Information of Determining Eligibility for Benefits

I hereby authorize the Montgomery Independent School District to obtain from medical practitioners, medically related facilities, insurance companies, information about my physical or mental condition relating to this claim. I understand that I have a right to receive a copy of this authorization. I agree that a photographic copy is as valid as the original.

________________________ __________________ ____________

Staff Member's Signature Phone Number Date

Describe in lay terms the nature of illness or injury:____

____

Explain the short-term and long-term prognosis:____

____

Would you categorize this person's illness as terminal or life threatening?____________________________

____

Give dates hospitalized, if any, and name and address of hospital:

Name of Hospital:____________________________________ Date Admitted:_________________

Address of Hospital: ______________________________ Date Discharged:_______________

____

To your knowledge, what is the earliest date this patient was treated for this condition?________________

Is patient still under your care? Yes____ No_____

As you understand the patient's job responsibilities with MISD and from your professional assessment of the patient's current condition, can you recommend that this person return to work at this time to perform the regular job assignment?

Yes____ No_____ If "No" please explain____

____

Has patient had the same or a similar condition in the past? Yes____ No_____

If "yes," state when and describe:____

____

Could the condition be treated during one of the District's holidays/breaks (see attached schedule)?___________

______________________________ __________________

Signature of Physician Date

____

Type or Print Physician's Name

____

Address

____

Area Code/Phone Number

Mail this form to:

Montgomery Independent School District
P. O. Box 1475
Montgomery, TX 77356