HOBBS MUNICIPAL SCHOOLS
FAMILY AND MEDICAL LEAVE ACT
PHYSICIAN'S FORM

TO BE COMPLETED BY EMPLOYEE:

PATIENT'S NAME: _____ SS#: _____

ADDRESS: _____ PHONE: _____

SCHOOL LOCATION: _____

I authorize Dr. _____ to release further information to the Hobbs Municipal Schools if deemed necessary.

_____ _____
Employee's Signature Date

TO BE COMPLETED BY PHYSICIAN:

Your patient is currently applying for leave with the Hobbs Municipal Schools through the Family and Medical Leave Act of 1993. The Hobbs Municipal Schools needs the following information to determine if the patient's medical condition meets the requirements defined by the Family Leave Act.

Date of onset of medical condition? _____

What is the nature and severity of the condition: _____

_____

Is surgery needed to relieve this condition? _____

How long will the condition be acute? _____

How long will the patient need for convalescence? _____

Anticipated follow-up visits? _____

During this time period, will the patient be: ⊙ Fit for Duty ○ Fit for limited Duty ○ **Not fit for Duty

Limitations: _____

****If not fit for duty, when do you project the patient would be fit for limited duty?** (Please give an approximate date) _____

What would the limitations be at that time? _____

When do you project the patient would be fit for full duty? (Please give an approximate date) _____

_____ _____
Physician's Signature Date

_____ _____
Physician's Address / Telephone Number Physician's I.D. Number