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: ____

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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