# Livingston Parish Public Schools

Mail Original to: LPPS/Human Resource Department
Post Office Box 1130
Livingston, Louisiana 70754-1130
Phone: 225-686-7044

LPPS Office Use Only
HR Approval _____
Other _____

## PHYSICIANS VERIFICATION FORM

(Complete top section before presenting to physician.)

**EMPLOYEE #:** _____ **SOCIAL SECURITY #:** _____

**NAME:** _____ _____ _____
(Last Name) (First Name) (Middle Initial)

**AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize the undersigned physician to release any information required in the course of my examination or treatment to Livingston Parish Public Schools.

_____ _____
Applicant's Signature Date

**TO BE COMPLETED BY PHYSICIAN** **Patient's Name** _____

**Brief description of illness/condition in layman's terms:** _____

_____

_____

***Is it <u>medically necessary</u> for the employee to be absent from work?*** ☐ YES ☐ NO

**Per Louisiana R.S.17:1202, a catastrophic illness or injury is defined as a life-threatening, chronic, or incapacitating condition affecting an employee or a member of an employee's immediate family, as verified by a licensed physician. In your opinion, does the patient's medical condition qualify as a catastrophic illness or injury?** ☐ YES ☐ NO

**If this leave is for maternity, when is the *Estimated Delivery Date*?** _____
**Month/Day/Year**

**Will delivery be by C-Section** ☐ YES ☐ NO

Patient is under my care and unable to work from _____ to _____
**Month/Day/Year – the first day missed** **Month/Day/Year – the last day missed**

**DATE PATIENT WILL BE ABLE TO RESUME FULL DUTIES**: _____
**(THE LAST DAY MISSED CAN NOT BE THE RETURN TO WORK DAY)** **Month/Day/Year – the day to return to work**

Physician's Name (*Please print*): _____ Office Phone #: _____

Office Address: _____
Street City State Zip

**Subject to the provisions of Louisiana R.S.14:125, I hereby sign the sworn statement that the information provided above is true and correct.**

Physician's Signature:

_____ _____
Date

***NOTE: A signature stamp is not acceptable and must be a physician's original signature.***