



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 _____

Received _____

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 medically necessary 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:

NOTE: A signature stamp is not acceptable and must be a physician's original signature. Nurses or nurse practitioners are NOT authorized to sign. Date