CITY SCHOOL DISTRICT ATTENDING PHYSICIAN'S STATEMENT

(To Be Completed by Physician)

For use in reviewing employee request for CATASTROPHIC ILLNESS LEAVE

The patient is responsible for completion of this form without expense to the District. IMPORTANT: Items 7 and/or 8, if applicable, must be completed on reverse side. Name of Patient Date of Birth Dav Address Street State Zip Code Name of Employer ROCHESTER CITY SCHOOL DISTRICT Health Insurance Group/Policy No. **HISTORY** (a) When did symptoms first appear or accident happen? Mo. Day Year (b) When did patient cease work because of disability? Mo. Day Year (c) Has patient ever had same or similar condition? T Yes □ No If "Yes" state when and describe. Is condition due to injury or sickness arising out of patient's employment? (d) ☐ No ☐ Unknown ☐ Yes Names and addresses of other treating physicians? (e) DIAGNOSIS (Including any complications) Mo. _____ Day _____ Year _____ (a) Date of last examination: Diagnosis (including any complications): (b) (c) Subjective symptoms: Objective findings (including diagnosis of current X-rays, EKG's, Laboratory Data and any clinical findings): (d) DATES OF TREATMENT (a) Date of first visit: Mo. _____ Day _____ Year _____ (b) Mo. _____ Day _____ Year _____ Date of last visit: (c) ☐ Monthly Other ☐ Specify NATURE OF TREATMENT (Including surgery, physical therapy, counseling, and medications prescribed, if any.) **PROGRESS** Has patient Recovered? (a) ☐ Improved? ☐ Stabilized? ☐ Retrogressed? Is patient (b) ☐ Ambulatory? ☐ House Confined? ☐ Bed Confined? ☐ Hospital Confined? (c) Has patient been hospital confined? If "Yes" give name and address of hospital. ☐ Yes ☐ No Confined from through (over)

6	CARDIAC (If Applicable)								
(a)	Functional capacity (American Heart Assoc.) Class 1 (No Limitation) Class 2 (Slight Limitation)								
				☐ Class 3 (Marke	d Limitation)	Class 4 (Cor	mplete Limit	tation)	
(b)	Blood Pressur	e (last visit)	Systolic _		Diastolic				
7	PHYSICAL IMPAIRMENT (As defined in Federal Dictionary of Occupational Titles)								
	Class 1 \$ Class 2 \$ Class 3 \$ Class 4 \$ Class 5 \$ Class 5	Class 2 Medium minimal activity (15-30%). Class 3 Slight limitation of functional capacity: capable of light work (35-55%). Class 4 Moderate limitation of functional capacity: capable of clerical/administrative (sedentary) activity (60-70%).							
8	MENTAL/NERVOUS IMPAIRMENT (if applicable)								
(a)		"stress" as it applies to this claimant. nd problems in interpersonal relations has claimant had on ich?							
(b)	What stress and problems in interpersonal relations has claimant had on job?								
	Class 1 🔖 Class 2 🔖	Class 2 Patient is able to function in most stress limitations and engage in most interpersonal relations (slight limitations). Patient is able to engage in only limited stress situation and engage in only limited interpersonal relations (moderate							
	Class 3 limitations). Class 4 Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations). Class 5 Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations).								
9	PROGNOSIS								
Expected Return to Work Date:									
10 REMARKS									
	Attending Physician Name (PRINT)			Degree	Degree Specialty			Telephone No.	
		Address			City or T	own	State	Zip Code	
	Signature							Date	
	Please Return Completed Form c/o:								

Rochester City School District • Employee Benefits • 131 West Broad Street • Rochester, New York 14614