

Arkansas State University-Newport
Catastrophic Leave Bank Program
PHYSICIAN'S CERTIFICATE

Please print or type. Supporting documents may be attached.

Patient Name: _____

DOB: _____

1. Diagnosis: _____

2. When did patient first seek treatment for this illness/injury? _____

3. To your knowledge, has patient ever had the same or similar condition? No Yes

If yes, state when and

describe: _____

4. Is surgery: Required Elective Date of Surgery:

5. Please give a brief narrative of the nature and extent of the illness / injury: _____

6. Prognosis for patient's ongoing care, if any?

7. If there are no further complications, what is the minimum recovery time of the patient before the employee may return to work? Approximate return date: _____

8. Can the employee return to work earlier with modified job duties or on a part-time basis?

No Yes If yes, please explain:

9. If patient is family member of employee, how long will employee be required to be off work to care for patient? _____

Doctor's Name: _____ Clinic: _____

Address: _____ Phone Number: _____

Doctor's Signature: _____ Date: _____