Selma City Schools

PHYSICIAN CERTIFICATION OF CATASTROPHIC ILLNESS OR INJURY

NAME OF PATIENT: _____

I hereby certify that the above listed individual is a patient of mine and is suffering an illness or injury which will cause the patient to be absent from work for an extended period of time which is estimated by me to be at least one of the following·:

☐ One Week ☐ Two Weeks ☐ Three Weeks

☐ One Month ☐ Indefinitely ☐ Permanently

☐ Other: _____

OTHER COMMENTS:

Signature of Physician: _____

Date: _____

Please return this form to the chairperson of the Sick Leave Bank.

Print Clear