NEW BRAUNFELS ISD

ATTENDING PHYSICIAN'S STATEMENT

PATIENT'S NAME_____

Nature of catastrophic sickness or injury:_____

_____

Please explain treatment being provided:_____

_____

_____

Check Yes or No on the lines below:

YES	NO	
_____	_____	Did patient have an outpatient procedure?
_____	_____	Was inpatient hospitalization of the employee required?
_____	_____	If patient had surgery, was it elective?
_____	_____	If surgery was required, could it have been postponed?
_____	_____	Is patient still under your care?

To your knowledge, what is the earliest date this patient was treated for this condition?_____

How long was or will patient be continuously and totally incapacitated?_____

Date patient can return to work to full duty with no restrictions?_____

If hospitalized, please give name and dates:

Hospital Name:_____

Date Admitted:_____ Date Discharge:_____

_____ _____

Signature of Physician Date

_____

Typed or printed physician's name