Los Rios Community College District

FIVE MONTH LAW
PHYSICIAN'S VERIFICATION OF INJURY/ILLNESS FORM
California Education Code §87780 and §88196

For Completion by the PHYSICIAN – All Sections are REQUIRED

Patient's Name: _____

Medical Facts:

Physician's diagnosis of injury/illness supporting the absence. (A diagnosis is required for tracking purposes only as there are limits on the number of days available for each injury or illness per the collective bargaining contract.) *Please list the diagnosis and not symptoms/treatments*:

_____

_____

The above-referenced diagnosed injury/illness prohibits the above-named patient from working on the following **begin date:** _____ **through:** _____

(Date range employee is off work.)

Date employee is (or is anticipated to be) released to return to work: _____

(Date employee will be back at work, *i.e. first workday after "through date" above.*)

Restrictions associated with the return to work (if yes please list below): ☐ YES ☐ NO

_____

_____

_____

*** Physician's signature:** _____ **Date:** _____

Signature by a physician or designee, nurse practitioner, surgeon, physician's assistant, psychiatrist, chiropractor or dentist will be accepted. Documents submitted in lieu of this form will be accepted **provided all the required information and signature is included.*

PRINT Name including TITLE(e.g. M.D., N.P.): _____

Business address: _____

Phone: ( ) _____ **FAX: ( )** _____

Questions about this form may be directed to the Los Rios Employee Benefits Department at (916) 568-3070.