PHYSICIAN’S VERIFICATION
OF INJURY/ILLNESS

** This form is NOT to be used for
Five Month Law OR Catastrophic Leave **

Patient's Name: ________________________________________________

The above-referenced patient has an injury/illness which prohibits them from working.

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 work day after “through date” above.)

Any 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 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.