LOS RIOS
COMMUNITY COLLEGE DISTRICT

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.