

**ST. CLAIR COUNTY BOARD OF EDUCATION**  
**410 Roy Drive, Ashville, AL 35953**

**PHYSICIAN CERTIFICATION FORM**

Name of Injured Employee (Last, First, MI)		Social Security #	Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address		Phone (H)  (W)	Job Title	Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Contract
Date of Injury	Is there reasonable expectation that the employee will be able to return to work? <input type="checkbox"/> YES <input type="checkbox"/> NO			
	If "YES", give the approximate date of return _____			
<p>If the employee can return to work, are there any restrictions on the employee's duties? If so, how long will the restrictions apply?</p>				
<p>If the employee will not be able to return to work, give details why the employee will not be able to return to work.</p>				
Name of attending Physician		Signature of physician		Date