

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

**PHYSICIAN CERTIFICATION OF  
CATASTROPHIC ILLNESS OR INJURY**

Name of Patient: \_\_\_\_\_

I hereby certify that the above listed individual is a patient of mine and is suffering an illness or injury which will cause the patient to be absent from work for an extended period of time which is estimated by me to be at least one of the following:

One Week

Two Weeks

Three Weeks

One Month

Two Months

Three Months

Other \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name of Physician: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

\_\_\_\_\_

Signature of Physician: \_\_\_\_\_

**\*\* Please return this form to the Payroll Department  
with other leave forms at the end of the pay period.**