THOMAS COUNTY SCHOOLS

200 N. Pinetree Blvd., Thomasville, GA 31792 229-225-4380 229-225-5012 Fax

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PHYSICIAN'S CONFIRMATION OF EMPLOYEE DISABILITY

Name of Patient: _____

Beginning Date of Leave: _____

Physician's Address: _____

Physician's Phone: _____ Fax: _____

Type of Practice/Specialization _____

Barring unforeseen complications, it is expected that this patient's period of physical disability will end on _____.

A statement of description of appropriate medical facts regarding the patient's health condition for which FMLA leave is requested and restrictions:

_____

_____

_____

_____

_____

_____

Physician's Signature: _____ Date: _____

Print Physician's Name: _____