Irvine Unified School District
Human Resources - 5050 Barranca Parkway, Irvine, CA 92604-4652, 949/936-5000 ext. 5130, FAX 949/936-5139

VERIFICATION OF DISABILITY

Medical leaves of absence must be verified by a licensed medical doctor. Please have your physician complete all appropriate sections below.

PATIENT'S NAME: _____

TREATMENT RECORD:

1. The patient is/will be under my care for the present medical condition from (date)_____ to (date) _____, at intervals of _____.
   Treatment dates (please specify): _____ _____ _____ _____.
2. Describe the nature, severity, and extent of the incapacitating disease or injury:
3. Diagnosis confirmed by x-ray or other test: YES NO
   Findings:

FOR PREGNANCY-RELATED DISABILITY:

4. The patient is now pregnant: YES NO
5. If YES, expected date of delivery _____
6. Is the maternity care routine: YES NO
7. If NO, state nature and severity of maternal pathology:

FOR SURGERY PATIENTS:

8. Surgery performed/to be performed on (date) _____
9. Type of surgery _____

HOSPITALIZATION:

10. Hospital name _____ Address: _____
11. Date entered _____ Date Discharged _____

DISABILITY STATEMENT:

12. Will the patient be incapable of performing his/her regular work: YES NO
13. If YES, enter date the disability commenced _____.
14. Approximate date, in your opinion, disability should end and patient may resume work (date) _____.

I hereby certify that the above statements, in my opinion, truly describe the patient's disability and the estimated duration thereof, and that I am a _____ licensed physician in the state of California.
(type of physician)

_____ _____ _____
Physician's name License Number Telephone

Address: _____

Date:_____

PHYSICIAN COMMENTS: