



DIAGNOSIS & FUNCTIONAL LIMITATIONS FORM

646-4319

TO THE EMPLOYEE:

For continuing absence, additional forms must be submitted as per leave policy or when requested by your principal, supervisor, or the Human Resource Office. If making application for short-term and/or long-term disability benefits, you acknowledge that you cannot perform the essential functions of your job with or without reasonable accommodation. Your signature on this form certifies the accuracy of the information contained herein. Failure to provide this form in a proper and timely manner could result in some loss of leave benefits and/or disciplinary action.

| | | | | | |
|--|--|--|-------------------|--|-----------|
| Employee ID #: | | Full Name (Last, First, Middle Initial): | | Phone Number | |
| Street Address: | | | City: | State: | Zip Code: |
| Work Location: | | | Current Position: | Check if job description attached <input type="checkbox"/> | |
| I, the undersigned, authorize the release, to Granite School District, of relevant medical information to determine leave, benefits or return to work eligibility. | | | | My last actual day worked is / was: | |
| Employee's Signature | | | | Date | |
| | | | | (MM/DD/YYYY) ___ / ___ / ____ | |

ATTENDING PHYSICIAN'S STATEMENT

| DIAGNOSIS | | | |
|---|---|---|---|
| ICD-10 / DSM-IV Diagnosis and Code Number: | If pregnancy, est. delivery date: | Approximate date condition commenced: | Probable duration of condition: |
| TREATMENT | | | |
| Date of first visit: | Date of last examination: | Date of next visit: | Frequency of visits: <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other |
| Has patient been hospital confined: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, confined from ___ / ___ / ____ to ___ / ___ / ____ | | | |
| Date(s) you treated patient for condition: | Was prescription medication prescribed? <input type="checkbox"/> Yes <input type="checkbox"/> No | Was patient referred to other health care provider(s) for evaluation or treatment ? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, state the nature of treatment and expected duration: | |

| ABILITY TO WORK | |
|---|---|
| If the patient has demonstrated a loss of function, please provide restrictions and limitations and the date they began below: | |
| Is the employee unable to perform any of his/her job functions due to the condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, identify the job functions the employee is unable to perform: | Expected date of return to work: (MM/DD/YYYY) ___ / ___ / ____ |
| Limitations (What the patient CANNOT do) | |
| Restrictions (What the patient SHOULD NOT do) | |

| | | | | | |
|------------------------------|--|----------------------------|---------------|---------------|------------------|
| Name of Attending Physician: | | Area of Medical Specialty: | | | |
| Phone Number: | | Fax Number: | | Office Hours: | |
| Street Address: | | | City or Town: | | State: Zip Code: |
| Physician's Signature: | | | | | Date: |



FUNCTIONAL LIMITATIONS FORM

| | |
|--|--------------|
| Full Name (Last, First, Middle Initial): | Phone Number |
|--|--------------|

Supervisor's Copy

ABILITY TO WORK

If the patient has demonstrated a loss of function, please provide restrictions and limitations and the date they began below:

Is the employee unable to perform any of his/her job functions due to the condition?

Yes No If so, identify the job functions the employee is unable to perform:

Expected date of return to work: (MM/DD/YYYY)

___ / ___ / ____

Limitations (What the patient CANNOT do)

Restrictions (What the patient SHOULD NOT do)