

Physician's Statement
Godley Independent School District
Catastrophic Sick Leave Bank

For Godley I.S.D. Employees with catastrophic Illness or Injury

Patient's Name _____

Address _____

Diagnosis or nature of illness or injury (lay language) _____

To be filled out by Physician

Date of Consultation _____

Date Hospitalized:

Admitted _____ Discharged _____

Prognosis _____

Date patient will be able to return to work (if known) _____

Total Disability from _____
through _____

Pre-Existing Condition YES _____ NO _____

Comments or
Restrictions _____

Physician's Name _____

Address _____ Zip _____

Telephone _____

Signature of Physician _____