MOUNTAIN BROOK SCHOOLS
PHYSICIAN CERTIFICATION FORM

All sections must be completed as they pertain to the injury

SCHOOL DISTRICT Mountain Brook City Schools School: _____

Date of Incident: _____ Time of Incident: _____

INJURED PERSON

1. Name _____ Age _____ Phone # _____

2. Address

PREMISES CONDITION

3. Check the type of premises and conditions

Type of Premises: Conditions: Notified Police Dept.:

Report No.:

INCIDENT DESCRIPTION*

4. Briefly Describe What Happened

WITNESSES* Provide Full Name, Address & Phone # of Each Witness

5. Name Address Phone #

_____

_____

DESCRIPTION OF INJURY*

6. Injury - Describe the Type, Severity, Body Part Involved

6a. Was Medical Treatment Given? ☐ Yes ☐ No

6b. Name of Medical Facility/Doctor _____

PHYSICIAN'S COMMENTS

7. Is there a reasonable expectation that the employee will be able to return to work? ☐ Yes ☐ No

If "yes" on item 7, give the date of approximate date of return.

8. If the employee can return to work, are there any restrictions on the employee's duties? If so, how long will the restrictions apply?

9. If "no" on item 7, give details for employer not being able to return to work.

Signature of Attending Physician **Print Name** **Telephone Number** **Date**

Print

SIGNATURES ARE REQUIRED TO COMPLETE AND PROCESS FORM.

Reset Form