(585) 262-8206 CITY SCHOOL DISTRICT ROCHESTER, NEW YORK

ATTENDING PHYSICIAN'S STATEMENT

(To Be Completed by Physician)

For use in reviewing employee request for CATASTROPHIC ILLNESS LEAVE

The patient is responsible for completion of this form without expense to the District.

IMPORTANT: Items 7 and/or 8, if applicable, must be completed on reverse side.

Name of Patient _____ **Date of Birth** ____/____/____
Mo. Day Yr.

Address _____
No. Street City State Zip Code

Name of Employer ROCHESTER CITY SCHOOL DISTRICT **Health Insurance Group/Policy No.** _____

1 HISTORY

(a) When did symptoms first appear or accident happen? Mo. _____ Day _____ Year _____

(b) When did patient cease work because of disability? Mo. _____ Day _____ Year _____

(c) Has patient ever had same or similar condition? ❒ Yes ❒ No

If "Yes" state when and describe. _____

(d) Is condition due to injury or sickness arising out of patient's employment? ❒ Yes ❒ No ❒ Unknown

(e) Names and addresses of other treating physicians? _____

2 DIAGNOSIS (Including any complications)

(a) Date of last examination: Mo. _____ Day _____ Year _____

(b) Diagnosis (including any complications): _____

(c) Subjective symptoms: _____

(d) Objective findings (including diagnosis of current X-rays, EKG's, Laboratory Data and any clinical findings):

_____

3 DATES OF TREATMENT

(a) Date of first visit: Mo. _____ Day _____ Year _____

(b) Date of last visit: Mo. _____ Day _____ Year _____

(c) Frequency: ❒ Weekly ❒ Monthly ❒ Other ❒ Specify

4 NATURE OF TREATMENT (Including surgery, physical therapy, counseling, and medications prescribed, if any.)

_____

_____

5 PROGRESS

(a) Has patient ❒ Recovered? ❒ Improved? ❒ Stabilized? ❒ Retrogressed?

(b) Is patient ❒ Ambulatory? ❒ House Confined? ❒ Bed Confined? ❒ Hospital Confined?

(c) Has patient been hospital confined? ❒ Yes ❒ No If "Yes" give name and address of hospital.

_____ Confined from _____ through _____

_____

(over)

6 CARDIAC (If Applicable)

(a) Functional capacity (American Heart Assoc.) ❒ **Class 1** (No Limitation) ❒ **Class 2** (Slight Limitation) ❒ **Class 3** (Marked Limitation) ❒ **Class 4** (Complete Limitation)

(b) Blood Pressure (last visit) Systolic _____ Diastolic _____

7 PHYSICAL IMPAIRMENT (As defined in Federal Dictionary of Occupational Titles)

❒ Class 1 ↳ No limitation of functional capacity: capable of heavy work. No restrictions (0-10%).
❒ Class 2 ↳ Medium minimal activity (15-30%).
❒ Class 3 ↳ Slight limitation of functional capacity: capable of light work (35-55%).
❒ Class 4 ↳ Moderate limitation of functional capacity: capable of clerical/administrative (sedentary) activity (60-70%).
❒ Class 5 ↳ Severe limitation of functional capacity: incapable of minimal (sedentary) activity (75-100%).

8 MENTAL/NERVOUS IMPAIRMENT (if applicable)

(a) Please define "stress" as it applies to this claimant. _____

(b) What stress and problems in interpersonal relations has claimant had on job? _____

❒ Class 1 ↳ Patient is able to function under stress and engage in interpersonal relations (no limitations).
❒ Class 2 ↳ Patient is able to function in most stress limitations and engage in most interpersonal relations (slight limitations).
❒ Class 3 ↳ Patient is able to engage in only limited stress situation and engage in only limited interpersonal relations (moderate limitations).
❒ Class 4 ↳ Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations).
❒ Class 5 ↳ Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations).

9 PROGNOSIS

Expected Return to Work Date: _____

10 REMARKS

_____

_____

_____

_____

Attending Physician Name (PRINT) | **Degree** | **Specialty** | **Telephone No.**

Address | **City or Town** | **State** | **Zip Code**

Signature | **Date**

Please Return Completed Form c/o:
Rochester City School District ♦ Employee Benefits ♦ 131 West Broad Street ♦ Rochester, New York 14614