FORM I

C O N F I D E N T I A L

TRUMBULL PUBLIC SCHOOLS
Trumbull, Connecticut

INITIAL DISABILITY FORM

I hereby authorize my doctor to release the information requested below to my employer, Trumbull Public Schools.

_____ _____ _____
Employee Name Employee Signature Date

This form is given to you as the physician of the above named employee of the Trumbull Public Schools. This employee has notified the Board that s/he is (expects to be) disabled. To enable the Board of Education to satisfy its legal obligation toward this employee and to insure that the employee receives the disability benefits to which s/he is entitled under law and his/her contract, we request that you complete this form.

If you are **unable** at this time to determine any of the requested dates, **please so note**. If either of the estimated dates below designating the period of disability changes as a result of a physical condition which you conduct or on about each of said dates, please advise your patient of these changes so that s/he may notify the Human Resources Office immediately.

Please complete Form I after patient's initial office visit and return it directly to the employee or mail to the Human Resources Office, Trumbull Public Schools, 6254 Main Street, Trumbull, CT 06611.

I, Dr. _____ am physician to _____
(Please print) (Please print)

who is currently under my care for: _____
(Please print)

a. I certify that as a consequence of his/her condition, s/he will be physically disabled from performing his/her duties as an employee of the Trumbull Public Schools effective _____ with an anticipated return to work date of _____..

    i. If disability is due to pregnancy, I estimate the date of delivery to be on or about _____.

_____ _____
Physician's signature Office address

_____

_____ _____
Date Telephone number