FORM II

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

TRUMBULL PUBLIC SCHOOLS
Trumbull, Connecticut

RELEASE OF DISABILITY

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

_____________________________ _____________________________ ___________________
Employee Name Employee Signature Date

Please complete Form II after patient's last office visit **or** at the end of the six/eight week check-up (if disability is due to pregnancy) 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 s/he is no longer physically disabled and may return to work effective

_______________________________.

_____________________________ _____________________________
Physician's signature Office address

____

_____________________________ _____________________________
Date Telephone number