ATTENDING PHYSICIAN STATEMENT
FMLA CERTIFICATION FORM
ALEXANDER CITY SCHOOL SYSTEM
ALEXANDER CITY, ALABAMA

Please complete the following information:

Employee's Name_____ SSN:_____
Name of injured/ill person (if other than employee):_____
_____

Description of current injury/illness:_____
_____
_____
_____

Physician's recommendation:_____
_____
_____

Date individual first seen by physician for this injury/illness:_____

Estimated length of absence from work in days:_____

I certify that the information above concerning the named employee of the Alexander City Board of Education is correct.

Please type or print physician's name and address:

_____ **_____**
_____ **Signature of Attending Physician**
_____