(To Be Completed by LPISI	D Employee)				
Last Name	First Name	MI	Employee ID#		
Campus/Department			Position		
authorize the La Porte Indep practitioners, medically relation	bendent School District Catastrophi ted facilities, insurance companies, to the claim. I know that I have a	c Sick Leave Bank or my employer, i	nining eligibility for benefits. I hereby to receive from and/or provide to medical nformation as to any physical or mental opy of this authorization. I agree a		
Staff Member's Signatur	re		Date		
	PHYSICIAN'S	S STATEM	ENT		
Describe in lay terms	s the nature of illness or in	jury:			
Explain the short-ter	m and long-term prognosis	8:			
Would you categoriz	this medical procedure a	as an emergend	cy? Yes No		
*LPISD Board Policy of "The term <i>catastrophic</i> in		mployee Sponsor y serious and imp	Yes No red Catastrophic Sick Leave Bank states: mediate nature, normally involving the		
Has patient had same	e or similar condition in th	e past?	Yes No		
-					
Is surgery recommen	ided? If so,	when?			
Give dates of treatme	ent:				
Give dates of hospita	lization, if any, and name	and address of	f hospital:		
(Name of Hospital)		(Date Admitted)		
(Hospital Address)		((Date Discharged)		

Is condition due to a pregnancy?	Yes	No	
Is patient still under your care?	Yes	No	
Date of next doctor appointment			
As you understand the patient's job re	esponsibilities with	n LPISD, from you	ur professional
assessment of the patient's current co	ndition, can you re	commend this pe	rson to return to
work at this time to perform the regul	ar job assignment?	Yes	No
Anticipated date patient can return to Date:		nature of Physicia	
	Typ	pe or Print Name	of Physician
	Phy	vsician Address	
	City	y/State/Zip Code	

Physician's Office Phone Number

PLEASE RETURN THIS FORM TO THE PATIENT OR FAX TO LA PORTE ISD PAYROLL DEPT (281)604-7119