Granite School District Fax Number (801) 646-4204

Granite School District

DIAGNOSIS and FUNCTIONAL LIMITATIONS FORM

TO THE EMPLOYEE:

1. For continuing absence, additional forms must be submitted as per leave policy or when requested by your principal, supervisor, or the Human Resource Office.
2. By making application for short-term and/or long-term disability benefits, you acknowledge that you cannot perform the essential functions of your job with or without reasonable accommodation.
3. Your signature on this forms certifies the accuracy of the information contained herein. Your signature also authorizes the release, to the District, of medical information regarding your ISD-10 or DSM-IV diagnosis.
4. Failure to provide this form in a proper and timely manner could result in loss of leave benefits and/or disciplinary action.

1. Social Security Number:	2. Full Name (Last, First, Middle Initial):	3. Phone Number:

4. Street Address: City: State: Zip Code:

5. Describe how and where accident occurred or describe the onset and nature of your illness:

I, the undersigned, authorize the release of any and all reports to Granite School District.

Employee's Signature: Date:

ATTENDING PHYSICIANS STATEMENT

DIAGNOSIS

ICD-10 / DSM-IV Diagnosis and Code Number:

If pregnancy, est. delivery date:

Delivery Type:
☐ Vaginal ☐ C-Section

Subjective Symptoms:

Objective Findings (including current X-rays, EKG's, laboratory data and any clinical findings):

TREATMENT

Date of first visit:	Date of last examination:	Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other ___________

Nature of treatment (including medications prescribed, surgery, etc.):

ABILITY TO WORK

If the patient has demonstrated a loss of function, please provide restrictions and limitations **and the date they began** below:

Restrictions (What the patient SHOULD NOT do)

Limitations (What the patient CANNOT do)

PROGRESS

Is patient: ☐ Ambulatory ☐ Hospital Confined ☐ Bed Confined ☐ House Confined

Has patient been hospital confined: ☐ Yes ☐ No
If yes , confined from ________________ to _______________
Name & address of hospital ____

Has patient: ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed
Comments:

PROGNOSIS

Patient is:

☐ Disabled short-term / temporarily ☐ own occupation ☐ any other occupation
☐ Disabled long-term / totally disabled ☐ own occupation ☐ any other occupation

Date patient became disabled due to present illness/injury:

When do you expect a fundamental or marked change in the future?
☐ 1 month ☐ 1-3 months ☐ Never This applies to: ☐ own job ☐ any job

Expected date of return to work: (ESTIMATIONS NOT ACCEPTABLE)

Name of Attending Physician:	Area of Medical Specialty:

Phone Number:	Fax Number:	Office Hours:

Street Address:	City or Town:	State:	Zip Code:

Physician's Signature:	Date: