TO BE COMPLETED BY ATTENDING PHYSICIAN
(Please type or print)

****

1. Patient's Name _____ Age _____

2. Please state:
   (a) Patient's complaints _____
   _____

   (b) Objective finding (Including results of X-rays, laboratory tests, diagnostic studies, B/P, etc., if relevant)_____
   _____

3. Give all dates of treatments by you during this period of catastrophic illness/injury:
   Office: _____
   Hospital: _____

4. If the patient was confined as a registered bed patient in a legally constituted hospital during this period, answer the following:
   (a) Name & address of hospital or facility _____
   (b) Date of admission _____, 20___ Date of discharge _____, 20___

5. If any surgical procedure was performed during this period of catastrophic illness or injury, please complete the following:

   Date of procedure _____, 20 ___ Procedure performed _____
   _____
   _____

6. Has the patient recovered sufficiently to return to work? YES _____ NO _____
   a) If "yes," give the date the patient was able to return to work . _____
   (b) If "No," when, in your opinion, may work be resumed? (Please do not use the terms "Indefinite," "Unknown" Undetermined," etc.) If a definite date cannot be determined, please approximate in days, weeks or months, how long the total disability will continue from the date of the most recent treatment as indicated above.
   _____

7. Is the patient MENTALLY capable of transacting his/her duties with realization of the nature and consequences of such acts? YES _____ NO _____

Physician's name and title (Please type or print) _____
Specialty Board Certification _____ Phone #_____
Office address _____
Date completed _____, 20___ Physician's Signature _____

DAYTON PUBLIC SCHOOLS
MEDICAL QUESTIONNAIRE

TO BE COMPLETED BY EMPLOYEE

Employee Group _____

1. Name _____ Birthdate _____ Male____ Female____
   Employment date _____ Social Security No._____ Home Phone # _____
2. Home Address _____
   (street) (city) (state) (zip)

   If you are or expect to be elsewhere during absence from work, give details including address and telephone number.

   _____

   _____
   (street) (city) (state) (zip)

3. Please explain your catastrophic illness or injury. Give a detailed description. (Use a separate sheet if necessary.)

   _____

   _____

   _____

4. On what date did you last work? _____, 20___

5. On what date were you first totally disabled by this catastrophic illness/injury? _____, 20___

6. On what date were your first treated by a physician for this catastrophic illness/injury? _____

7. If not now afflicted by the catastrophic illness/injury, on what date were you able to resume work? _____, 20____.

8. Give full name and address of <u>each</u> physician who treated you during this period of disability:

   <u>NAME</u> <u>ADDRESS</u>

   _____

   _____

   _____

9. Explanation of Previous Sick Leave Usage (Use separate sheet)

10. Date Sick Leave was (will be) exhausted. _____

11. Have you applied for disability? _____

I authorize any physician, surgeon, or other person who has treated or examined me or whom I have consulted for any purpose, and any hospital, clinic, or institution at which I have been treated, examined, or confined, to divulge and make available to Dayton Public Schools, or their designated representatives, any and all information concerning my catastrophic illness/injury including all psychiatric and psychological information and tests. This authorization shall be valid for one year from the date shown below. A photocopy of this authorization shall be as valid as the original.

Date completed _____, 20___ Signature of Employee _____