DENTON INDEPENDENT SCHOOL DISTRICT
Risk Management Department
1307 N. Locust St.
Denton, TX 76201
940-369-0030
940-369-4980 - fax

DENTON INDEPENDENT SCHOOL DISTRICT

MEDICAL CERTIFICATION FOR TEMPORARY DISABILITY LEAVE (TDL)

This form must be completed by your treating physician

Employer Name and Contact: Denton Independent School District
Risk Management Department
Attn: Phyllis Klein
Fax: 940-369-4980
email: pklein@dentonisd.org

Employee's Job Title: _____ Regular Work Schedule _____

Employee's Essential Job Functions: _____

_____

Completion by the EMPLOYEE

Your Name: _____
First Middle Last

Completion by the HEALTH CARE PROVIDER

Provider's Name and Business Address: _____

_____

Type of Practice / Medical Specialty: _____

Telephone: (___) _____ Fax: (___) _____

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

2. Is the medical condition pregnancy? ❒ Yes ❒ No If yes, expected delivery date: _____

Is the employee unable to perform any of his/her job functions due to the condition? ❒ Yes ❒ No

If so, identify the functions employee is unable to perform: _____

_____

3. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ❒ Yes ❒ No

   If so, estimate the beginning and ending dates for the period of incapacity: _____

   _____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider **Date**