Rib Lake School District

ATTENDING PHYSICIAN'S STATEMENT

For Spouse/Child/Parent of Employee

Patient Information:

_____

Last Name First Name Middle Initial Relationship to Employee

Employee's Information:

_____

Last Name First Name Middle Initial Position

Authorization to Release Information of Determining Eligibility for Benefits

I hereby authorized the School District of Rib Lake to obtain from medical practitioners, medically related facilities, insurance companies, information about my Spouse/Child/Parent's physical or mental condition relating to this claim. I understand that I have the right to receive a copy of this authorization. I agree that a photographic copy is as valid as the original.

_____

Employee Signature Phone Number Date

……

To be completed by Physician:

Describe in lay terms the nature of illness or injury:_____

_____

Explain the short-term and long-term prognosis:_____

_____

Would you categorize this as a life-threatening illness Yes ☐ No ☐ or extreme life circumstance Yes ☐ No ☐ .

_____

Has the patient had the same or a similar condition in the past?_____

If "yes," state when and describe:_____

_____

_____ _____

Signature of Physician Date

_____

Print Physician's Name

_____

Address

_____

Phone Number

Form can be returned by any method listed below:

Mail: Rib Lake District Office,
PO Box 278, Rib Lake, WI 54470

Fax: 715-427-3221

Email: jpeterson@riblake.k12.wi.us

Questions? Call 715-427-3222 ext. 3560