

**SHELBY COUNTY BOARD OF EDUCATION
MEDICAL CONFIRMATION FORM**

(Complete Release Form before presenting to physician)

NAME (As listed on Social Security Card)

_____ (Last Name) _____ (First Name) _____ (Middle Initial)

SOCIAL SECURITY NUMBER: _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned physician to release any information required in the course of my examination or treatment to the Shelby County Board of Education.

_____ Applicant's Signature _____ Date

TO BE COMPLETED BY PHYSICIAN

BRIEF DESCRIPTION OF ILLNESS/CONDITION IN LAYMAN'S TERMS _____

Is this treatment or surgery elective? (____ Yes) (____ No)

Patient is under my care and unable to work from _____ (Month/Day/Year) _____ (Month/Day/Year)

DATE PATIENT WILL BE ABLE TO ASSUME FULL DUTIES: _____

Physician's Name (Please Print) _____

Office Telephone Number: _____

Office Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

_____ Physician's Signature _____ Date

PHYSICIAN: Please return to patient for submission to:

*Human Resource Department
Shelby County Board of Education
160 S. Hollywood Street
Memphis TN 38112*