

**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: _____ **Date of Birth:** _____

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 _____ to _____
(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*