DIAGNOSIS & FUNCTIONAL LIMITATIONS FORM (DFL)

Note to Physician:
Please *FAX* completed form to:
385-646-4319

TO THE EMPLOYEE:

- → For continuing absence, additional forms must be submitted as per leave policy ***(every 21 calendar days for teacher contract; every 30 calendar days for administration, and; every 30 calendar days for classified)*** or when requested by your principal, supervisor, or the Human Resource Office.
- → ***Doctor's notes are not acceptable. All fields of this form MUST be completed.***
- → If filing application for short-term and/or long-term disability benefits, you acknowledge that you cannot perform the essential functions of your job with or without reasonable accommodation.
- → Your signature on this form certifies the accuracy of the information contained herein.
- → Failure to provide this form in a proper and timely manner can result in some loss of leave benefits and/or disciplinary action.

Employee ID#:	Last Name:	First Name, MI	Phone Number
Street Address:	City:	State:	Zip Code:
Current Position:	Work Location:	Supervisor:	Supervisor phone number:

I, the undersigned, authorize the release, to Granite School District, of relevant medical information to determine leave, benefits or return to work eligibility.

My last actual day worked is/was:

Employee's Signature:	Date:	__ __ / __ __ / __ __

ATTENDING PHYSICIAN'S STATEMENT

DIAGNOSIS

ICD-10/DSM-IV Diagnosis and Code Number:	If pregnancy, est delivery date:	Probable Duration of Condition: Days_____ Weeks _____ Months_____	Was medication prescribed? YES ☐ NO ☐
Date Treated for Condition _____/_____/_____	Estimated Date of Return: _____/_____/_____	Was the patient referred to another health care provider for evaluation or treatment? YES ☐ If yes, please provide other physician's contact information: NO ☐	

Upon returning to work, can the employee complete the essential functions of their job? YES ☐ NO ☐

Is this a Workers Comp claim? YES ☐ NO ☐

Upon returning to work, please list any restrictions the employee may have:

***Actual* date Released to work:**
_____/ _____/ _____

PHYSICIAN INFORMATION

Printed name of Attending Physician:	Area of Medical Specialty:	
Phone Number:	Fax Number:	Office Hours:
Street Address:	City:	State: Zip Code:
Physician's Signature:		Date:

For Office Use Only
Date Received: _____/_____/_____ Email Supervisor: ☐ Update Spreadsheet: ☐ DFL Assigned to: _____