Diagnosis & Functional Limitations Form (DFL)

This form is confidential and should only be faxed to: 385-646-4319

NOTE TO THE EMPLOYEE:

- → For continuing absence, additional forms must be submitted as per leave policy (***every 21 calendar days: contract teacher; every 30 calendar days: administration; every 30 calendar days: classified)*** or when requested by your principal, supervisor, or the Human Resources Office.
- → ***Doctor's notes are not accepted. No exceptions. 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:	☐ 9 Mo ☐ 9.5 Mo ☐ 10 Mo ☐ 10.5 Mo ☐ 12 Mo Monthly Contract:	Work Location:	Supervisor:	Supervisor Phone #:

I, the undersigned, authorize the release to Granite School District, of relevant medical information to determine leave, benefits or return to work eligibility.		Employee's Last Day Worked is/was:
Employee's Signature:	Date:	______/______/______

Attending Physician's Statement:

Diagnosis

ICD-10/ DSM-IV Diagnosis & 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 ☐ No ☐ ***If yes, please provide other physician's contact information:***

Upon returning to work, can the employee complete the essential functions of their job? Yes ☐ No ☐	Is this a Worker's 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 ____________