

# Arlington Central School District Office of Human Resources

696 Dutchess Turnpike  
Poughkeepsie, NY 12603  
845-486-4460

## MEDICAL DISABILITY FORM\*

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TO: \_\_\_\_\_, M.D.

Your patient \_\_\_\_\_ (*print name*) has indicated to us that he/she will soon be disabled and will be unable to attend usual employment. The employee will be applying for sick time during this period of disability at full pay, and it is necessary for the District to receive a full report on the nature and extent of the disability. Please provide the following information:

1. Nature of disability \_\_\_\_\_

2. State probable start date of disability \_\_\_\_\_

3. State probable end date of disability \_\_\_\_\_

4. **If this is for childbirth**, state expected delivery date \_\_\_\_\_

5. Check one:

The disability prevents the employee from performing his/her usual duties

The employee may perform some duties during the period of disability  
please explain \_\_\_\_\_  
\_\_\_\_\_

6. State the prognosis for recovery \_\_\_\_\_

7. State the date when the employee may be expected to return to full or partial employment  
\_\_\_\_\_

8. Please state any additional information which may be helpful or pertinent \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Physician's Name (please print): \_\_\_\_\_

Business Phone: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

**PLEASE RETURN TO PERSONNEL OFFICE, ARLINGTON CENTRAL SCHOOL DISTRICT**

**\*FMLA LEAVE WILL RUN CONCURRENT WITH ANY DISABILITY.**