APPENDIX 6
Maple Heights City Schools
PHYSICIAN CERTIFICATION

This section must be completed by a physician for any employee who has exceeded five (5) consecutive days of sick leave.

This certifies that on _____, 20_____,

I treated _____, (patient) for

(employee's condition or length of required absence to care for immediate family member)

_____ _____

Date Signature of Licensed Physician

Address: _____

Phone: _____