 Form GARH-2

Benefits Office

CCSD Human Resources

P. O. Box 1088 Marietta, GA 30061

Fax # 678-594-8580

Please type or print clearly in ink.

**DISABILITY CERTIFICATION**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **I. Employee Identification** | | | | |  | **II. Patient Identification** | | | | |
| Social Security Number: xxx – xx - | | |  | |  | Does this certification relate  Yes  to the employee?  No  ---------------------------------- OR ----------------------------------  Does this certification relate  Yes  to a seriously ill family member?  No  If the certification relates to a seriously ill family member, provide the following information: | | | | |
| Last Name | First | | | Initial |  |
| Apartment/Box/Route | | | | |  |
| Street Address | | | | |  |
| City, State | | Zip Code | | |  | Last Name | First | | Initial | |
| Work Location | | Daytime Telephone  Number  (     ) | | |  | Relationship to Employee | | Date of Birth | | |
| Month | Day | Year |
|  |  |  |

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| --- |
| **III. Physician Statement** Complete for the patient in Section II |
| - If the patient is the employee, will the patient be able to perform normal job duties during the period of disability?  Yes  No  - If the patient is not the employee, is the employee’s presence necessary or beneficial to the care of the patient?  Yes  No  - If the disability is due to pregnancy, please give the expected date of delivery. \_\_\_\_\_\_\_\_  - If the disability period exceeds two weeks prior to delivery or six weeks after the deliver, please give detailed medical information that supports  the additional period of disability.  - Describe the disability – give diagnosis and detailed statement of patient’s physical condition (attach additional sheets if necessary).   |  | | --- | |  | |  | |  | |  | |  | |  | |  | |  | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **IV. Physician Certification** | | | | | | | |
| Physician’s Name | | Date Disability Begins | | | Estimated Date Disability Ends | | |
| Month | Day | Year | Month | Day | Year |
| Group Name | |  |  |  |  |  |  |
| Suite | Daytime Telephone Number | I certify that the above named patient is under my care. Adjustments in these date may be necessary at a later time.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_  Physician’s Signature (no Stamps, Please) Date | | | | | |
| Street Address | |
| City, State | Zip Code |