

AFFIDAVIT  
FOR  
CERTIFYING TEMPORARY DISABILITY

Patient's name: \_\_\_\_\_ Date: \_\_\_\_\_

Name of attending physician: \_\_\_\_\_

Patient's present job location and assignment: \_\_\_\_\_

SPECIFIC NATURE OF DISABILITY (To be completed by the attending physician)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Initial date of disability (Date patient was recommended to cease regular duty):

\_\_\_\_\_

Anticipated ending date of disability (Date patient is authorized to return to duty):

\_\_\_\_\_

I hereby attest that the above mentioned patient/person has a physical or mental condition that rendered him/her incapable of performing the regular assigned duties of his/her work assignment with Irving ISD during the dates of \_\_\_\_\_ through \_\_\_\_\_.

\_\_\_\_\_  
Signature of patient (employee)

\_\_\_\_\_  
Signature of attending physician