ROCHESTER CITY SCHOOL DISTRICT

CERTIFICATE OF PERSONAL ILLNESS (CPI)

Name: _____ **Date of Application:** _____
(Print) Last Name First Initial

Position or Assignment: _____ **School or Department:** _____

Employee ID # _____ **Employee Phone Number** _____

PART I - EMPLOYEE'S CERTIFICATE

To be used for illness of more than three days or at the request of Administrator, in accordance with contractual language (excluding RTA).

I hereby certify that I was absent from my duties beginning from _____ through _____
Month Day Year Month Day Year

***If unsure about return date leave date blank.**

A total absence of _____ days due to _____

Employee Signature : _____ **Date:** _____

PART II - PHYSICIAN'S CERTIFICATE

As a duly licensed physician, I certify that between the dates _____ and _____

the above -mentioned person was medically incapacitated for school duties and was seen and treated by me on the following date(s):

_____

State the nature and extent of the illness: _____

This patient may return to work on: _____

Returned with restrictions? YES ☐ NO ☐ If Yes, please list nature of restrictions: _____

_____

Are days absent from work the result of a Workers' Compensation injury sustained during the course of employment?
YES ☐ NO ☐ .

Signature of Physician: _____ **Date:** _____

Address: _____

This form should be returned to the Benefits Department at 131 West Broad Street, Rochester, NY 14614 or emailed to: leaveofabsenceapplication@rcsdk12.org.

Revised 01/18