STATE OF MISSOURI
DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION

# LEAVE SHARE PROGRAM
# PHYSICIAN'S STATEMENT

**CONFIDENTIAL**

TO BE COMPLETED BY PHYSICIAN (Please type or print legibly)

| EMPLOYEE NAME | DATE |
|---|---|
| PATIENT NAME | SOCIAL SECURITY NUMBER |
| NATURE OF ILLNESS OR INJURY | DATE OF ONSET OF CONDITION |

DIAGNOSIS

Could the condition result in permanent disability? ☐ Yes ☐ No If yes, please attach detailed explanation.

Could the condition be life threatening if not treated? ☐ Yes ☐ No If yes, please attach detailed explanation.

PROGNOSIS - PLEASE PROVIDE A DETAILED PROGNOSIS. (Attach sheet if additional space is needed)

Is hospitalization required? ☐ Yes ☐ No If yes, what is the anticipated length of stay?

LENGTH OF RECOVERY

ANTICIPATED DATE TO RESUME JOB RESPONSIBILITIES

If the employee is not the patient, is his/her absence from work required to care for the patient? ☐ Yes ☐ No
If yes, please describe the type of care he/she will be required to provide the patient.

| SIGNATURE OF PHYSICIAN | PRINTED NAME OF PHYSICIAN | PHYSICIAN PHONE NO. |
|---|---|---|
| | | |

12/15/06