WALLACE COMMUNITY COLLEGE SELMA
PHYSICIAN CERTIFICATION OF CATASTROPHIC ILLNESS OR INJURY

Name of patient: _____

I hereby certify that the above listed individual is a patient of mine and is suffering an illness or injury which will cause the patient to be absent from work for an extended period of time which is estimated by me to be at least one of the following:

_____ Three Weeks _____ One Month _____ Indefinitely _____ Other

Other Comments: _____

Signature of Physician: _____

Date: _____

Print Physician's Name: _____

Physician's Address: _____

**Please return this form to the Human Resource/Business Office.