PHYSICIAN CERTIFICATION OF DISABILITY
TO SERVE AS A SCHOOL BUS DRIVER (form 6301-C)

This form is to be completed and submitted to the Superintendent of Watauga County Schools by July 1 of each year of the disability. The form is required to certify the employee's inability to drive a school bus due to a disability as diagnosed by the attending physician.

EMPLOYEE CERTIFICATION:

Name:

_____

First Middle Last

Social Security Number: ____ - _____ - _____
Position/School Assignment: _____
Home Phone: (_____) _____ - _____

I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment relative to this disability to the Watauga County Board of Education. I understand that this information is to be furnished at no cost to Watauga County Schools unless otherwise specified.

_____ _____
Employee's Signature Date

PHYSICIAN CERTIFICATION:

I hereby certify that I first treated _____ for his/her disability
(Name of Patient)
on _____ and that he/she is disabled to perform his/her job requirement as a
(Month/Day/Year)
school bus driver with a diagnosis of _____

The prognosis is that the total length of this disability will be approximately:

_____

Physician's Name (Please Print) _____

Signature _____ Date _____

Address Phone:
