FORT BEND INDEPENDENT SCHOOL DISTRICT
3119 Sweetwater Blvd.
Sugar Land, TX 77479

CATASTROPHIC ILLNESS SUPPLEMENT BENEFIT
Request for Medical Report

In order to receive benefits under the Catastrophic Illness Supplement Benefit, the following documentation must be submitted by the attending health care provider:

Name of Employee:____

Social Security Number:____

Date of Birth:____

The Medical Report must include:

- The nature of the illness and/or extent of injury that is preventing the employee from working.
- Confirm that the employee must be absent from work for treatment or recovery directly related to his/her catastrophic illness/injury.
- The anticipated number of days necessary for recovery to return to work on a full or part-time basis.
- The date the employee will be capable to return to work on a full or part-time basis.

** Please note that benefits will not be processed if information is incomplete.

Name of attending health care provider:____________________________________

Degree & Medical Specialty:____

Street Address:____

Telephone Number:____

Fax Number:____

Signature of attending health care provider (No Stamp):	Date: