

**CERTIFICATE OF PERSONAL ILLNESS (CPI)** Teacher Absence Civil Service AbsenceName: \_\_\_\_\_ Date of Application: \_\_\_\_\_  
(Print) Last Name First Initial

Position or Assignment: \_\_\_\_\_ School or Department: \_\_\_\_\_

**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

AM OR PM OR BOTH	1st Payroll Week					2nd Payroll Week				
	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY

A total absence of \_\_\_\_\_ days due to \_\_\_\_\_

Employee Signature : \_\_\_\_\_ Address: \_\_\_\_\_

Principal/  
Supervisor 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: \_\_\_\_\_

Are days absent from work the result of a Workers' Compensation injury sustained during the course of employment?

YES  NO  If Yes, forward a copy of this form to the Benefits Department.

Signature of Physician: \_\_\_\_\_ MD Date: \_\_\_\_\_

Address: \_\_\_\_\_

This form should be maintained at the Building/Department Level, per HIPAA guidelines.