

MEDICAL CERTIFICATION

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|---|-------------------------|-------|
| Employee: | | |
| Employee Name: | | |
| Supervisor Name: | | |
| Department: | | |
| Date Leave Commences: | Date of Planned Return: | |
| <p>I am requesting to take a medical leave of absence from employment. I understand that I must use all sick and annual leave prior to requesting leave share or short term disability. I understand I must provide medical certification for leave approval consideration and medical certification to return to work. I also understand light duty work and medical accommodations may be requested, if needed.</p> | | |
| Employee Signature: | Date: | |
| Health Care Provider: | | |
| <p>REQUEST FOR LEAVE: Describe the <u>medical facts</u> which support your certification:</p> <p>State the approximate date the condition commenced, and the probable duration of the condition: Beginning on _____ and ending _____.</p> | | |
| <p>RETURN TO WORK CERTIFICATION: I have examined the above employee and can certify that she/he is fully able to resume working, beginning on:</p> <p>_____, 20 _____, with:</p> <p><input type="checkbox"/> No Restrictions <input type="checkbox"/> The Following Restrictions:</p> | | |
| Health Care Provider Name: | | |
| Medical Practice Name: | | |
| Address: | | |
| City: | State: | Zip: |
| Health Care Provider Signature: | | Date: |