

MEDICAL CERTIFICATION

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 style="margin-left: 40px;"> <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: