MEDICAL CERTIFICATION

Employee:	
Employee Name:	
Supervisor Name:	
Department:	
Date Leave Commences:	Date of Planned Return:
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.	
Employee Signature:	Date:

Health Care Provider:		
REQUEST FOR LEAVE: Describe the <u>medical facts</u> which support your certification: State the approximate date the condition commenced, and the probable duration of the condition: Beginning on _____ and ending _____.		
RETURN TO WORK CERTIFICATION: I have examined the above employee and can certify that she/he is fully able to resume working, beginning on: _____, 20 _____, with: ☐ No Restrictions ☐ The Following Restrictions:		
Health Care Provider Name:		
Medical Practice Name:		
Address:		
City:	State:	Zip:
Health Care Provider Signature:		Date: