

SICK LEAVE BANK
MEDICAL CERTIFICATION FORM
(To be submitted with Sick Leave Bank Request Form)

To be completed by the Employee:

Name of Patient Social Security Number D.O.B.

Address Street City State Zip Code

I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment for the purpose of the Sick Leave Bank.

Signed Patient Signature Date

To be completed by Attending Physician

Patient's condition is the result of: Illness Injury

Is condition due to illness or injury that is work related? Yes No

Diagnosis:

Primary Diagnosis:

Subjective symptoms:

Test Results (list all results)

Test: Date: Results:

Test: Date: Results:

Treatments:

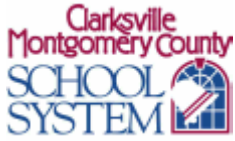
Date you first treated this patient for this condition:

Date of onset of this condition: Date of most recent treatment:

How often has patient been seen/treated? Date of next office visit:

Has patient been referred to any other physician? Yes No If "yes" Date(s):

Name of Physician:



Specialty: \_\_\_\_\_

Nature of treatment for this condition: \_\_\_\_\_

Has surgery been performed?  Yes  No If "yes" date: \_\_\_\_\_ Procedure: \_\_\_\_\_

Was patient hospitalized for this condition?  Yes  No If "yes" dates admitted: \_\_\_\_\_

Dates discharged: \_\_\_\_\_ Name of hospital: \_\_\_\_\_

Please complete the following questions regarding your patient's status:

1. Is your patient able to work?  Yes  No If no, what medical restrictions or limitations have been placed on this patient preventing his/her return to work?

\_\_\_\_\_  
\_\_\_\_\_

Expected return to work date (mm/dd/yyyy): \_\_\_\_\_

2. Nature of treatment/treatment plan (including surgery, therapy, and medication prescribed, if any).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
*Medical Provider's Signature*

\_\_\_\_\_  
*Date (mm/dd/yyyy)*