

Optional Medical Certification Statement for the Employee's Own Illness

Medical Certification Statement (Employee's Own Serious Illness)

Name of Employee: _____

Date Condition Began: _____

Date Condition Ended (or is expected to end): _____

Medical facts regarding the condition: _____

Explanation of extent of which employee is unable to perform the functions of his or her job:

Health Care Provider Signature: _____

Date: _____

Office Phone: _____

Medical Release:

I authorize the release of any medical information necessary to process the above request.

Patient's Signature: _____

Date: _____