STATE EMPLOYEE-TO-EMPLOYEE LEAVE DONATION PROGRAM

MEDICAL CERTIFICATION FORM
TO BE COMPLETED BY TREATING PHYSICIAN

EMPLOYEE'S NAME: _____

PATIENT'S NAME (if not employee): _____

DIAGNOSIS(ES): _____

ICD 10 CODE(S): _____ _____ _____ _____

SUMMARY OF TREATMENT(S) & PROCEDURE(S): _____

_____

_____

START DATE OF CURRENT INCAPACITY: _____

SURGERY DATE (IF APPLICABLE): _____

HOSPITALIZATION DATE(S) (IF APPLICABLE): FROM: _____ **TO:** _____

CAN EMPLOYEE WORK IN A MODIFIED CAPACITY? YES: _____ **NO:** _____

IF YES, PROVIDE RESTRICTIONS FOR MODIFIED DUTY:

_____

_____

PROVIDE DATE EMPLOYEE IS LIKELY TO RETURN TO:

MODIFIED DUTY: _____ **FULL DUTY:** _____

_____ _____

PHYSICIAN'S NAME (PRINTED) **PHYSICIAN'S PHONE NUMBER**

_____ _____

PHYSICIAN'S SIGNATURE **DATE FORM COMPLETED**

(PLEASE ATTACH MEDICAL VERIFICATION OF SURGERY OR BIRTH; TYPE OF BIRTH IS REQUIRED)

Failure to provide sufficient medical documentation may delay the processing of this request. This information shall be treated as a confidential medical record; it shall not be placed in the employee's personnel file. Only those individuals with a need to know this information will be given access to it. An employee who fails to appropriately safeguard the confidentiality of this information will be subject to disciplinary action, including termination from State Service.