STATE EMPLOYEE-TO-EMPLOYEE LEAVE DONATION PROGRAM

MEDICAL CERTIFICATION FORM (REQUIRED)
TO BE COMPLETED BY TREATING PHYSICIAN

EMPLOYEE'S NAME: _____

PATIENT'S NAME (if not employee): _____

DIAGNOSIS(ES): _____

_____

ICD 10 CODE(S) (Required): _____ _____ _____ _____

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

START DATE OF CURRENT INCAPACITY: _____

SURGERY DATE (IF APPLICABLE): _____

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

DATE EMPLOYEE IS LIKELY TO RETURN TO **FULL DUTY** (**REQUIRED**): _____

****

PLEASE COMPLETE THIS SECTION ONLY IF EMPLOYEE CAN RETURN IN A MODIFIED CAPACITY

MODIFIED RETURN DATE (IF APPLICABLE): _____ (**CANNOT BE SAME AS FULL**)

PROVIDE RESTRICTIONS FOR MODIFIED DUTY (**REQUIRED WITH A MODIFIED DATE**):

****

_____ _____

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

_____ _____

PHYSICIAN'S SIGNATURE (WET SIGNATURE) **DATE FORM COMPLETED**

(PLEASE ATTACH REQUIRED MEDICAL VERIFICATION OF SURGERY)

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.