To the Physician:

has been asked to provide a medical certificate explaining the reasons for the need for medical leave from **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**until **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (please confirm dates)**

**Employee’s Authorization to Release Information**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize my physician to complete this physician’s statement and to release this Medical Certificate to my employer.

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

Employee Signature Date

**Physician’s Statement - Confirmation of Reasons for *Extended* Medical Leave**

1. Following examination, I certify that the above mentioned person requires an extended medical leave due to:

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

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1. This illness will prevent this person from working because:

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

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1. Course of Treatment
   1. Has this person been prescribed a course of treatment for the medical condition rendering him/her unable to work his/her full assignment?

\_\_\_\_Yes \_\_\_\_No

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

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* 1. If no course of treatment has been prescribed, has a course of treatment been recommended for this person to follow related to the medical condition rendering him/her unable to work his/her full assignment?

\_\_\_\_Yes \_\_\_\_No

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

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* 1. If a course of treatment has been prescribed or recommended has this person followed the prescribed or recommended course of treatment?

\_\_\_\_Yes \_\_\_\_No

* 1. Has this person been referred to a medical specialist?

\_\_\_\_Yes \_\_\_\_No

1. He/she was seen by me regarding this illness/injury on\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
2. What medical follow-ups, if any are occurring related to this illness/injury?

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

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1. I estimate that this person will be able to return to his/her full assignment on

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

1. When this employee returns to work I anticipate the following restrictions (please include duty restrictions, maximum hours per day, and estimated length of gradual return to work).

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

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For informational purposes this is to make you aware of the availability for employees of the Employee and Family Assistance program (EFAP). In addition, this school district uses the services of occupational health services providers to facilitate appropriate returns to work for our employees.

Name of Attending Physician (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postal Code \_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Physician’s Signature

***This information is considered confidential. Any charge for the completion of this form is the responsibility of the claimant.***