This form to be completed by the Health Care Provider.

Certification of Health Care Provider

Health Care Provider means a doctor of medicine, doctor of chiropractic, or doctor of osteopahy legally authorized to practice by the appropriate examing board.

Physician's Printed Name _____

Address _____

City/State _____ Zip Code _____

Office Phone # _____ License # _____

Physician to complete one of the following:

☐ Employee Disability Name of Employee: _____

Date Disability Commenced: _____

Probable Duration or Ending Date: _____

Describe the serious health condition that makes the employee unable to perform the essential functions of his/her employment. Attach additional page(s) if necessary.

_____

_____

_____

_____

☐ Care of Family Member Name of Family Member: _____

Date(s) employee presence necessary for care of immediate family member.

Beginning Date: _____

Probable Duration or Ending Date: _____

Describe the serious health condition of family member which requires the presence of the employee. Attach additional page(s) if necessary.

_____

_____

_____ _____

Date *Signature of Health Care Provider*

RETURN COMPLETED FORM TO EMPLOYEE.