Medical Certificate
Request for Extended Medical Leave

To the Physician:

______________________________________ has been asked to provide a Medical Certificate explaining the reasons for the need for extended medical leave from ____________________ to ____________.

Employee's Authorization for Release of Information

I, ____________________________ hereby authorize my physician to complete this Physician's Statement and to release this Medical Certificate to my Employer. The guidelines of the College of Physicians and Surgeons are attached.

Employee's 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:

   ____

   ____

   ____

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

   ____

   ____

   ____

3. Course of Treatment:

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

      ____

      ____

      ____

b. 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 assignment?

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____

____

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

____

____

____

d. Has this person been referred to a medical specialist?

Yes ________ No ________

4. He/she was seen by me regarding this illness/injury on ______________________.

5. What medical follow-ups, if any, are occurring related to this illness/injury?

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6. I estimate that this person will be able to return to their full teaching assignment on ____________________.

7. 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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8. For informational purposes, this is to make you aware of the availability for employees of the Employee and Family Assistance Program (EFAP).

Name of Attending Physician (please print)

Address ____ Postal Code__________

Phone____
Date_______________

Signature ____

The information in this report is considered confidential. Any charge for completion of this form is the responsibility of the claimant.