SICK LEAVE BANK
MEDICAL CERTIFICATION FORM

(To be submitted with Sick Leave Bank Request Form BEN-F052)

To be completed by the Employee:

Name of Patient: _____

Social Security Number: _____ **D.O.B.:** _____

Address:

_____

Street **City** **State** **Zip Code**

I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment for the purpose of the Sick Leave Bank.

Signed: _____ **Date:** _____
Patient Signature

To be completed by Attending Physician:

Patient's condition is the result of: ☐ Illness ☐ Injury

Is condition due to illness or injury that is work related? ☐ Yes ☐ No

Diagnosis:

Primary Diagnosis: _____

Subjective symptoms: _____

Test Results (list all results):

Test: _____ Date: _____
Results: _____

Test: _____ Date: _____
Results: _____

Treatments:

Date you first treated this patient for this condition: _____

Date of onset of this condition: _____ Date of most recent treatment: _____

How often has patient been seen/treated? _____ Date of next office visit: _____

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Has patient been referred to any other physician? ☐Yes ☐No If "yes" Date(s): _____

Name of Physician: _____ Specialty: _____

Nature of treatment for this condition: _____

Has surgery been performed? ☐Yes ☐No
If "yes" date: _____ Procedure: _____

Was patient hospitalized for this condition? ☐Yes ☐No If "yes" Date(s) admitted: _____

Dates discharged: _____ Name of hospital: _____

Please complete the following questions regarding your patient's status:

1. Is your patient able to work? ☐Yes ☐No If no, what medical restrictions or limitations have been placed on this patient preventing his/her return to work?

   _____

   _____

   _____

   _____

Expected return to work date (mm/dd/yyyy):_____

2. Nature of treatment/treatment plan (including surgery, therapy, and medication prescribed, if any).

   _____

   _____

   _____

   _____

Medical Provider's Name _____

Address _____

Phone _____

Medical Provider's Signature _____

Date _____