Medical Certification Statement
(Employee's Own Serious Illness)

Name of Employee: _____

Date Condition Began: _____

Date Condition Ended (or is expected to end): _____

Medical facts regarding the condition: _____

_____

_____

_____

Explanation of extent to which employee is unable to perform the functions of his or her job:

_____

_____

_____

Health Care Provider Signature: _____

Date: _____ Office Phone: _____

Medical Release:

I authorize the release of any medical information necessary to process the above request.

Patient's Signature: _____ Date: _____