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: ______________________________

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: ______________

SICK LEAVE BANK
MEDICAL CERTIFICATION FORM

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 ____