# Clarksville Montgomery County School System
# Health Care Provider Certification

**To be completed by Employee:**

Employee Name:_____ Employee ID#_____

Job Title: _____ Work Location:_____

Basic Job Duties:

_____

_____

_____

**To be completed by Health Care Provider:**

Providers name and business address:_____

Type of practice/medical specialty: _____

Telephone: _____ Fax: _____

Is the medical condition pregnancy? ☐ No ☐ Yes If so, expected delivery date:_____

Medical Condition preventing employee from working:

_____

_____

_____

Will the employee be incapacitated for a single continuous period due to this medical condition including any time for treatment and recovery? ☐ No ☐ Yes

If so, estimate the beginning and ending dates for the period of incapacity:_____

Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ☐ No _____Yes

Additional Information you would like to provide to the employer regarding this medical condition:_____

_____

_____

_____ _____

Signature of Health Care Provider Date