MEDICAL CERTIFICATION

Employee:		
Employee Name:		
Supervisor Name:		
Department:		
Date Leave Commences:	Date of Planned Return:	
I am requesting to take a medical leave of absence from employment. I understand that I must use all sick and annual leave prior to requesting leave share or short term disability. I understand I must provide medical certification for leave approval consideration and medical certification to return to work. I also understand light duty work and medical accommodations may be requested, if needed.		
Employee Signature:		Date:
Health Care Provider:		
State the approximate date the condition commenced, and the probable duration of the condition: Beginning on and ending RETURN TO WORK CERTIFICATION: I have examined the above employee and can certify that she/he is fully able to resume working, beginning on:, 20, with: No Restrictions		
Health Care Provider Name:		
Medical Practice Name:		
Address:		
City:	State:	Zip:
Health Care Provider Signature:		Date: