HRnovations
Your Partner in Growth

Medical Certification non-FMLA (employee's own medical condition)

1. Employee's Name

_____

2. Please describe the medical reason necessitating a leave of absence from work:

3. Will it be necessary for the employee to be (*please check all that apply and describe below)*:

___ a) **absent from work** ___ b) **work only intermittently** ___ c) **work less than a full schedule and/or work with limitations**

a) If absence from work is required, please provide an estimate of probable duration

b/c) If employee will be able to work only intermittently, less than a full schedule, or has work limitations, please provide:

1) likely duration _____

2) frequency of required absences _____

3) job related limitations (if any) _____

4) approved work schedule _____

4. Please provide:

Date condition commenced: _____

Probable duration of condition: _____ Probable duration of current incapacity:_____

Estimated return to work date: _____

5. If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (i.e. prescription drugs, physical therapy, etc.)

Signature of Health Care Provider: _____ Date: _____

Printed name of Health Care Provider: _____ Phone: _____

Type of Practice (Field of specialization, if any): _____