Medical Certification Form for Leave Request

Instructions: This form must be completed by a registered health care provider to support an employee's request for medical leave. Please print and complete all sections clearly.

Section 1: Employee Information

Employee Full Name:	
Employee ID / Number:	
Department:	
Job Title:	

Section 2: Medical Provider Information

Medical Practitioner Name:	
Medical Specialty:	
Business Address:	
Telephone Number:	
Email Address:	

Section 3: Medical Certification Details

Date Medical Condition Commenced:	MM/DD/YYYY
Probable Duration of Condition:	
Brief Description of Medical Condition:	
Prescribed Treatment Regimen:	

Section 4: Leave Recommendation

Recommended Leave Start Date:	MM/DD/YYYY
Recommended Leave End Date:	MM/DD/YYYY
Type of Leave (e.g., Continuous, Intermittent, Reduced Schedule):	
Describe Period of Incapacity (if applicable):	

Section 5: Signatures

By signing below, the health care provider and employee certify that the information provided is accurate and medically necessary.

Medical Provider Signature:	Sign on printed document	Date:	MM/DD/YYYY
Employee Signature:	Sign on printed document	Date:	MM/DD/YYYY