Physician Statement for Medical Leave

This form is to be completed by a licensed healthcare provider to certify a patient's need for medical leave. Please print and fill out all sections clearly.

Patient Information

Patient Full Name:

Date of Birth (MM/DD/YYYY):

Employee/Patient ID Number:

Physician / Medical Provider Information

Provider Name:

Medical Specialty:

State License Number:

Clinic/Hospital Name:

Phone Number:

Facility Address:

Medical Certification & Leave Details

Date of Examination (MM/DD/YYYY):

General Description of Medical Condition (Do not disclose highly sensitive details unless authorized):

Leave Start Date (MM/DD/YYYY):

Expected Return to Work Date (MM/DD/YYYY):

Type of Leave Required (Continuous, Intermittent, or Reduced Schedule):

Required Workplace Accommodations upon Return (If applicable):

Physician Signature & Attestation

I certify that the above-named patient has a medical condition that prevents them from performing their essential job functions for the period indicated above.

Physician Signature (Sign after printing):

Date of Signature (MM/DD/YYYY):