Medical Certification Form for Medical Leave

To be completed by the Healthcare Provider:

The employee named above has requested medical leave from work. To assist us in determining the employee's eligibility for leave, please complete this form and return it to the employee or directly to our HR department.

Healthcare Provider Information:

Provider Name: _____

Medical Practice Name: _____

Provider Address: _____

Provider Phone Number: _____

Provider Email: _____

Medical Certification

1. Patient's Condition:

Please describe the medical condition for which the employee is being treated:

2. Inpatient Care:

Has the employee been admitted for inpatient care in a hospital, hospice, or residential medical care facility?

☐ Yes ☐ No

If yes, provide the dates of admission:

From: _____ To: _____

3. Continuing Treatment:

Does the employee require continuing treatment by a healthcare provider?

☐ Yes ☐ No

If yes, please describe the nature and duration of the treatments:

_____

4. Incapacity:

Is the employee currently unable to perform any of their job functions due to the medical condition?

☐ Yes ☐ No

If yes, please describe the job functions the employee is unable to perform:

_____

5. Duration of Incapacity:

Date the condition commenced: _____

Probable duration of condition: _____

Probable duration of incapacity (if different): _____

6. Intermittent Leave:

Will it be necessary for the employee to take leave intermittently or to work on a reduced schedule because of the medical condition?

☐ Yes ☐ No

If yes, please provide the probable duration and frequency of such leave:

_____

7. Treatment Schedule:

Please provide the dates of any scheduled appointments, including the time required for each appointment and any recovery period:

_____

Additional Information

Please provide any additional information that you believe would be helpful in understanding the employee's need for medical leave:

_____
_____

Healthcare Provider Certification

I certify that the information provided above is true and correct to the best of my knowledge.

Healthcare Provider Signature: _____

Date: _____

Return this form to:
Harold Dutton III, CFO
The Common Market
428 E Erie Ave
Philadelphia, PA 19134
harold@thecommonmarket.org

Note: This information will be kept confidential and will only be used for the purpose of determining the employee's eligibility for medical leave.

Thank you for your assistance.