Foothill-De Anza Community College District
District Office of Human Resources
12345 El Monte Road, Los Altos Hills, CA 94022
Attn: Director of Human Resources

MEDICAL CERTIFICATION FORM
DOCUMENTING LIMITATION(S) or RESTRICTION(S)

Section 1: To be Completed by Employee

Name:_____ Employee CWID or SSN:_____
(Please print)

Phone/Contact Number:_____ Last Work Day Before Illness/Injury:_____

I AUTHORIZE ANY PERSON(S) having any records or knowledge of me or my health to give information on all medical information for myself, including medical history, diagnosis, prognosis and treatment of any physical or mental condition, and the dates I am/was unable to work due to medical reasons.

I UNDERSTAND a representative of the District Office of Human Resources may contact my provider regarding my absence, medical condition or return to work as provided above.

I UNDERSTAND that this authorization shall remain in force throughout the duration of my leave due to medical reasons from Foothill-De Anza Community College District and for 90 days thereafter.

_____ _____
Employee Signature Date

Section 2: To be Completed by Attending Physician/Medical Provider

1. I attended the patient for the present medical condition *from*:_____ *to*:_____

_____

2. History:

_____

3. Diagnosis:

If pregnant, expected delivery date:

Actual delivery date:

(OVER)

Please return completed form to: District Office of Human Resources. Address above. For questions call: (650) 949-6109.

Section 2: Continued

4. Begin date of first day of leave.

5. If the patient was hospitalized, please state the reason:

Name of hospital_____

Address_____City_____State_____Zip Code_____

Date admitted_____ Date discharged_____

6. Prognosis:

7. APPROXIMATE date patient may return to regular work:

Describe the patient's physical and mental limitations and work activity restrictions (*please refer to patient's job description*):

How long will the described limitations impair the patient?

When can patient return to 100% of duties?

8. Further comments (if indicated):

Signature of Attending Physician/Medical Provider

Name of Physician/Medical Provider (Please print): _____

Physician/Medical Provider's Licensed Specialty: _____

Address: _____

City_____ State_____ Zip Code _____

Area Code_____ Phone Number_____Taxpayer Identification Number _____

_____ _____

Signature of Physician/Medical Provider Date

Please note: All medical/health information is maintained in a confidential file separate from the employee personnel file. Access to this information is restricted by law to authorized persons only.

Please return completed form to: District Office of Human Resources. Address above. For questions call: (650) 949-6109.