FOOTHILL-DE ANZA
Community College District

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
Full Release to Return to Work
Without Limitation or Restriction

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 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 or return to work.

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. First day employee was unable to work:

_____

3. This employee is authorized to return to work ***without limitation(s) and may resume 100% of his/her hours and duties*** on the following date:

(If any limitation/s please use the FHDA Medical Certification Form Documenting Limitation/s or Restriction/s)

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 return completed form to: District Office of Human Resources. Address above.