FOOTHILL-DE ANZA COMMUNITY COLLEGE DISTRICT

OFFICE OF HUMAN RESOURCES AND EQUAL OPPORTUNITY

MEDICAL CERTIFICATION FORM

Section 1: To be completed by employee

Date:_____

Name:_____Social Security Number:_____
(please print)

Address:_____

City_____State_____Zip Code_____

Phone 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.

I understand that this authorization shall remain in force throughout the duration of my sick leave with the Foothill-De Anza Community College District.

_____
Signature

Section 2: To be completed by attending physician

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)

Section 2: Continued

4. Date you recommended patient should stop working:

_____

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:

How long will the described limitations impair the patient?

When can patient return to 100% of duties?

_____

8. Further comments (if indicated):

Name of physician:_____ Specialty:_____
(please print)

Address_____City_____State_____Zip Code_____

Area Code_____ Phone Number_____ Taxpayer Identification Number_____

Signature_____ Date_____

Please return completed form to: Foothill-De Anza Community College District
Office of Human Resources
12345 El Monte Road
Los Altos Hills, CA. 94022
Attn: Kristine Paulsen
Office: (650) 949-6222 Fax: (650) 949-2831