California State University, Monterey Bay
100 Campus Center, Tide Hall, Building 23, Seaside, CA 93955

Physician's Certification for Medical Leave

To ensure a safe and healthy working environment; we at CSUMB strive for timely and thorough communication with our employees and their doctors. Please feel free to contact University Personnel with any questions you may have at **831-582-3584**. You may also fax a completed form to **(831) 582-4736.**

This is to certify that _____ is under my care.
Employee Name

Pregnancy

Estimated due date:	**Estimated return to work date:**

Serious health condition

Date condition commenced:	**Estimated return to work date:**

YES:	**NO:**		**Duration:**
		Is inpatient **hospitalization** of the employee required?	
		Does the employee have an illness/injury which **totally** incapacitates him/her from performing work of any kind?	
		Is the employee able to **perform his/her job functions with limitations**? (Answer after reviewing attached job description) If accommodation is requested, please **list specific work restrictions below**.	
		Is the employee able to **work on an intermittent basis** or work less than his/her normal schedule? If so please **describe hours/days employee is able to work below *and provide a start and end date for these restrictions*.**	

Please list work restrictions or intermittent work schedule here *and specify the maximum number of hours per day and per week* that this employee is medically limited by your medical opinion, with a start and end date:

_____

_____

_____

_____

Print Physician's Name: _____

Type of Practice: _____

Physician's Phone Number: _____

Physician's Address: _____

Physician's Signature: _____ **Date:** _____