Human Resources
csumb.edu/hr
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Physician's Certification for Medical Leave and Catastrophic Leave Solicitation

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

Serious health condition:
Date condition commenced: _____ Estimated return to work date: _____
Pregnancy:
Estimated due date: _____ 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:
_____
_____
Specify the maximum number of hours per day and per week that this employee is medically limited by your medical opinion: _____
Start date of work restrictions or intermittent work schedule: _____
End date of work restrictions or intermittent work schedule: _____

Print physician's name: _____
Type of practice: _____
Physician's phone number: _____
Physician's address: _____

Physician's signature: _____