

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 <i>and provide a start and end date for these restrictions.</i>	

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: _____

Date: _____