

SAMPLE

PHYSICIAN'S CERTIFICATE

1. Employee's Name: _____

2. Please indicate whether the employee can perform each of the essential functions of his/her position as listed on page 1 of this package. If applicable, please state the probable duration of the condition that prevents the employee from performing one or more of the essential duties of his/her position as listed on the attached List of Essential Duties.

3. If the employee is unable to perform one or more of the tasks of the List of Essential Duties, is the employee ABLE to perform work of any kind such as "light duty"? Yes_____ No_____

4. If applicable, please provide examples of the types of activities the employee can perform without restrictions at this time.

5. If applicable, please provide examples of activities the employee can perform with restrictions at this time and the nature of such restrictions.

6. Will it be necessary for employee to work only intermittently or to work on a less than full schedule as a result of the condition? Yes_____ No_____

- If yes, please give the probable duration of this restriction. _____

7. If additional treatments will be required for the condition, please provide an estimate of the probable number of such treatments and the interval between such treatments (or the actual or estimated dates of treatment, if known).

Signature

Date