

PHYSICIAN'S CERTIFICATION

1. Employee's Name: _____

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

3. If the employee is unable to perform one or more of the essential duties listed on 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 restriction 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 the 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).

8. If any of these treatments will be provided by another provider of health services (e.g., physical therapist), please state the nature of the treatment.

9. If a regimen of prescription drugs is required under your supervision, will those drugs prevent the employee from safely performing any of the essential functions of his/her job?

Yes ____ No ____

Note: Here and elsewhere on this form the information sought related only to the condition which prevents the employee from performing the essential duties of his/her position.

Note: "Incapacity" for purposes of this document, is defined to mean inability to perform the essential duties of his/her position.

Original Signature of Physician

Date

Type of Practice

Telephone Number