



CIVILIAN MEDICAL DOCUMENTATION FORM

Date: _____

Name <i>last</i> _____ <i>first</i> _____		Title _____		Shield <i>(if applicable)</i> _____		SSN _____	
Bureau _____	Absent From: _____	AM PM	Date _____	Through: _____	AM PM	Date _____	Total Days /Hours _____

I was unfit for duty on account of illness/injury during this period. The nature of my illness or injury was _____

Name of treating physician/health care provider _____	Telephone No. _____
Address _____	_____
Employee Signature _____	Date _____

Failure to submit this application within five days after returning to work may result in loss of pay for the period in question and may also subject the employee to disciplinary action. The attending physician / health care provider must complete the following certification when the employee is absent for more than three consecutive work days and/or when required by a supervisor, before sick leave with pay will be approved.

ATTENDING PHYSICIAN'S / HEALTH CARE PROVIDER'S CERTIFICATION

(Employee is specifically restricted from writing in this section.)

I hereby certify that _____ was treated by me on the date(s) indicated above for medical treatment: Return to Work Date _____

Dates of treatment: Home _____ Office _____ Hospital _____

TREATMENT/PROGNOSIS *(Treatment/prognosis may be omitted when patient confidentiality may be a consideration).* _____

I further certify that this employee was incapable of performing his/her duties during the period from _____ to _____, and that the information in this section is true.

Physician's Stamp

Date: _____

Physician's / Health Care
Provider's Signature _____

License / Registration No. _____

FOR REFERRAL	<input type="checkbox"/> Approved	<input type="checkbox"/> Denied	<input type="checkbox"/> Referred
Immediate Supervisor _____	_____	_____	Date _____
	<i>(name)</i>	<i>(signature)</i>	
Reason: _____			

<input type="checkbox"/> Approved	<input type="checkbox"/> Denied	Endorsed by _____	Date _____
<i>(Unit Manager/Bureau Head or designee)</i>			
Forwarded to: <input type="checkbox"/> Bureau of Investigations & Trials			
<input type="checkbox"/> Other _____			