PHYSICIAN'S STATEMENT TO SUPPORT LEAVE OR RETURN FROM LEAVE

The EMPLOYEE IS RESPONSIBLE for having the physician complete this form and for the return of this form to the employee's department. This form is to be used in support of a leave (e.g., sick leave, leave without pay for illness or injury) for medical reasons, an extension of a leave for medical reasons, or return for medical reasons. Physicians' statements provided to insurance carriers or claims administrators are separate and will NOT substitute for the mation to be supplied to the employee's department to support a leave or return from leave.

TO BE COMPLETED BY THE EMPLOYEE

EMPLOYEE NAME	DEPARTMENT
DATE OF INJURY OR ILLNESS	NATURE OF ILLNESS

IF INJURY, WHERE, HOW, AND WHEN DID IT HAPPEN

I hereby authorize any physician or hospital to complete this form and to provide to the County the information requested on this form.

Employee Signature _____ Date _____

TO BE COMPLETED BY ATTENDING PHYSICIAN (PLEASE TYPE OR PRINT LEGIBLY)

DATE FIRST CONSULTED BY PATIENT	DATE INJURY OR SYMPTOMS FIRST APPEARED	DATE OF NEXT APPOINTMENT	PREGNANCY? Yes ☐ No ☐ If yes due date: _____

NATURE OF ILLNESS OR INJURY, SPECIFIC NATURE OF DISABILITY AND CURRENT CONDITION OF PATIENT.

Is the Condition Related to Employment?	Is the Patient Still Under Your Care?	Expected Duration of Treatment:	Period of Disability:	Patient was confined to Hospital:
Yes ☐ No ☐	Yes ☐ No ☐		Begin Date: _____ End Date: _____	From: _____ To: _____ Patient was confined to non-hospital treatment facility: From: _____ To: _____

NAMES OF OTHER PHYSICIANS TREATING PATIENT OR TO WHOM THE PATIENT WAS REFERRED:

PROGNOSIS:

E EMPLOYEE ABLE TO RETURN TO WORK WITHOUT ENDANGERING HIM/HERSELF OR OTHERS: _____

If there are ANY work limitations or restrictions, be sure to identify these specifically on the reverse side.

Exhibit I