Black Gold Regional Division No.18

BLACK GOLD REGIONAL DIVISION NO. 18

Medical Leave Certificate -

1. Employee's Name:
   _____
2. Employee's Position:
   _____
3. The employee was unable to work due to medical reasons beginning:
   - Date: _____
   - Nature of the illness: (Do Not Provide the Diagnosis)
     _____
     _____
4. Is the employee receiving treatment? Yes ___ No __ None required ___
5. Anticipated date of return to work:
   - Date: _____
   - If date unknown, the following is the likely length of the absence:
     __< 30 days __ 30-60 days __61-90 days __> 90 days __ Indeterminate
6. Anticipated date of next reassessment, if applicable: _____
7. If the employee is ready to return to work, is s/he
   - Fit and able to return to work with no restrictions? Yes __ No __
   - Fit and able to return to work with modified work? Yes __ No __

     List of work-related restrictions:
     _____
     _____
     _____

Date: _____

Attending Physician: _____ (signature)
_____ (please print name)

Work Address of Physician: _____

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