MEDICAL CERTIFICATION STATEMENT
(EMPLOYEE’S OWN SERIOUS ILLNESS)

Name of Employee: _________________________________________
Date condition began: _______________________________________
Estimate of probable duration of the condition: ______________________
Diagnosis of the serious health condition: ________________________________

Statement of the regimen of treatment prescribed for the condition (including estimated number of visits, nature, frequency, and duration of treatment; treatment by other providers; and whether in-patient hospitalization is required):

Explanation of the extent to which the employee is unable to perform the functions of his/her job:

Is the employee unable to perform work of any kind?
  Yes
  No
If the answer is yes, please explain:

Is the employee unable to perform the essential functions of his/her job?
  Yes
  No
If yes, please explain: _______________________________________________________________________________
_________________________________________________________________________________________________

Date:_________  Signature of Healthcare Provider:_________________________________
Type of Medical Practice:________________________________________________________________
Specialization, if any:_____________________________________________________________________
Office Telephone Number:________________________________________________________________

MEDICAL RELEASE

I authorize the release of any medical information, necessary to process my leave request, by my physician or other healthcare provider to the Gore school district.

Date:____________  Patient’s Signature:___________________________________________