Office of Human Resources
668 City Hall
Philadelphia, PA 19107
215-683-6950

FIRST JUDICIAL DISTRICT OF PENNSYLVANIA

Medical Certification

INSTRUCTIONS TO EMPLOYEE: RETURN COMPLETED FORM(S) TO THE OFFICE OF HUMAN RESOURCES.
In accordance with the FJD policies, this form must be completed by your licensed, health care provider in the following situations: (a) when using more than 2+ consecutive, Sick days for your own illness; OR (b) upon using any Sick Leave after being placed on the *"Excessive Use of Sick Leave"* list; OR (c) upon request from HR to establish *"Fitness For Duty"* and / or upon reporting to HR from an extended medical leave (i.e. 6+ consecutive days).

HEALTH CARE PROVIDER: Please answer all the questions below based upon your current examination / treatment of the patient who is an FJD employee. Amended information should be initialed, then sign and date the bottom on this form. Thank You for your cooperation.

Employee Name: _____

☐ was ☐ is under my professional care from _____ (Date) through _____ (Date)

Having examined this individual, it is my opinion that he/she:

☐ May return to work without restrictions*.

☐ May return to work with restrictions* described in *"Prognosis"* section below.

☐ May not be expected to return to work until: _____ (Date)

☐ Return unknown. Next medical evaluation on: _____ (Date)

PROGNOSIS: *Please note any essential job functions that the employee is unable to perform based on their job description. Please include a prognosis and the duration of any restrictions / limitations.

_____

_____

_____

_____

_____

The District reserves the right to determine whether any limitations or restrictions can be reasonably accommodated.

Please PRINT the following information:

Health Care Provider's Name: _____ Telephone Number: _____

Address: _____

The undersigned licensed, health care provider hereby verifies that the statements made herein are true and correct to the best of his/her knowledge, information and belief.

_____
Signature of Health Care Provider *Date*

Note to Employee: This form is to be signed upon reporting to HR on date of return from a medical leave.
I understand that making false or misleading statements will subject me to disciplinary action up to and including discharge.

_____
Employee Signature *Date*