Office of Human Resources
668 City Hall
Philadelphia, PA 19107
(215) 683-6950
Medical Fax: (215) 683-6991
Please include a cover

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.

Please excuse **(Employee / Patient Name)** _____

from work due to medical reason(s) beginning _____ *(Date)* through _____ *(Date)*

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

☐ May return to work **without** restrictions* on: _____ *(Date)*

☐ May return to work **with** restrictions* described in "Prognosis" below on: _____ *(Date)*

☐ Return is unknown. Please explain in "Prognosis" below.

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. If the employee is unable to return please provide a reason and the date of his/her next evaluation:

_____

_____

_____

_____

_____

_____

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: _____ Fax Number: _____

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 the date of your 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)*