

Medical Certification Form for Sick Leave Donations

To be completed by physician or other licensed health care provider.

Date: _____

Employee/patient's name: _____

Employee/patient's position title: _____

The above-named employee/patient is currently under my care. The employee/patient cannot perform the essential functions of the employee/patient's position with the Hidalgo County Government because of the employee/patient's serious health condition, which may include complications of pregnancy or childbirth, or recovery from childbirth.

The employee/patient's serious health condition began on _____.
(Please provide date)

I estimate that the patient will be able to return to work on _____.
(Please provide date)

Name of licensed health care provider: _____
(Please print)

Professional title: _____
(medical doctor, licensed physical therapist, etc.)

Work phone: _____

Other phone: _____

Address: _____

Signature: _____

Please return this form to the employee/patient.