SICK LEAVE CERTIFICATION
(Non-FMLA purposes)

You must provide this form and the enclosed job description to a treating physician who is knowledgeable about the injury or illness causing your absence from work. Submit the completed form to the County Manager's Office within twenty-four (24) hours being visiting the physician. It will be placed in your confidential medical file.

SECTION I: TO BE COMPLETED BY EMPLOYEE

Employee Name: _____

Department: _____

Supervisor: _____

SECTION II: TO BE COMPLETED ONLY BY THE HEALTH CARE PROVIDER

(The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information).

1. I have been provided, and have reviewed, the job description for this patient.
   Yes No (Circle One)

2. The patient has an injury, illness, or other medical condition that prevents them from performing the duties of their job. Yes No (Circle One)

Date the patient's condition began: _____

Date the patient can return to work: _____
("Return Date")

3. Identify the restrictions imposed on the patient by their injury, illness, or other condition that prevents them from performing their job duties before the Return Date:

_____

_____

_____

_____ Date: _____
Signature of Health Care Provider

_____ _____ _____
Type of Practice/Specialty Telephone Number e-mail address