05/01/2009

# MURRAY STATE UNIVERSITY
# SICK LEAVE BANK MEDICAL CERTIFICATION FORM

## Section I. Employee Information (Please Print)

Employee
Last Name ______________________________ First ______________________ M.I. _______ M No. ________________________

Department _______________________________ Position Title _________________________ Office Phone No. ______________

Home Phone No.______________________________ Cell Phone No._________________________________________________

## Section II. Medical Release

I authorize the release of any medical information necessary to complete this form. Knowingly providing false information directly, or through another party, may result in adverse action against the employee.

(1)____________________________________________________________ ______________________
Patient's or Responsible Party's Signature Date

## Section III. Physician's Statement (To be Completed by Physician)

Describe the medical facts regarding the condition, including a brief statement as to how these facts meet the criteria of a catastrophic illness or injury (serious accident, illness or extended hospitalization).

________________________________________________________________________________________________________

________________________________________________________________________________________________________

________________________________________________________________________________________________________

________________________________________________________________________________________________________

________________________________________________________________________________________________________

________________________________________________________________________________________________________

________________________________________________________________________________________________________

Date Condition Began ____________________________________ Anticipated Return to Work Date_____________________

Physician's Signature_______________________________________ Date of Next Appointment__________________________

Print Physician's Name________________________________________________ Date_____________________________________

**Return to:** **Human Resources**
**404 Sparks Hall**
**Murray State University**
**Murray, KY 42071**