

**APPENDIX T3**  
**MEDICAL CERTIFICATION STATEMENT**  
Foothill-De Anza Community College District

Name of Employee: \_\_\_\_\_

Is this Certification for the Employee \_\_\_\_\_ or for ill family member \_\_\_\_\_

Name of ill family member (patient): \_\_\_\_\_

Date Condition Began: \_\_\_\_\_

Date Condition Ended (or is expected to end): \_\_\_\_\_

Medical facts regarding the condition: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Explanation of extent to which employee is needed to care for ill family member: (if applicable)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Explanation of extent to which employee is unable to perform the functions of his or her job:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Health Care Provider Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_ Office Phone Number: \_\_\_\_\_

**Medical Release:**

I authorize the release of any additional information from my health care provider necessary to process the above request.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name \_\_\_\_\_

**Please return this form to Foothill-De Anza Community College District, District Office of  
Human Resources, 12345 El Monte Road, Los Altos Hills, CA 94022**