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