CS-1843
5/2014

MICHIGAN CIVIL SERVICE COMMISSION

Disability Management Unit
206 E. Michigan Avenue
P.O. Box 30003
Lansing, Michigan 48909

NON-FMLA MEDICAL CERTIFICATION BY PHYSICIAN OR PRACTITIONER

SECTION I — Authorization to Release Medical Information

I authorize my (or my minor child's) attending physician or practitioner to release the information requested below in Section II to the employee's employer regarding my (or my minor child's) physical or mental condition. This information will only be used as necessary to determine how it will affect the state employee's work activity in consideration of the request for a leave of absence. By signing this release, I certify that I am authorized to request the release of this information and I understand that I am agreeing that the employer may obtain and use such necessary medical information provided below about me (or my minor child), including information relative to HIV or AIDS, if applicable. This information is retained confidentially, consistent with applicable civil service rules, collective bargaining agreements, and state and federal law.

Employee's Name _____ Employee's ID No._____

Patient Name _____

Patient's (or Guardian's) Signature _____ Date _____

SECTION II — Certification of Medical Condition by Physician or Practitioner

This portion is to be filled out by the health care provider to certify the need for the employee's personal medical leave.

1. Patient Name	2. Relationship to Employee	3. Date Off Work	4. Probable Return to Work Date

5. Describe the medical facts, including the diagnosis and prognosis, that support your certification:

6. Regimen of treatment prescribed (indicate number of visits, general nature and duration of treatment, including referral to other provider of health services):

7. Is inpatient hospitalization required? ☐ Yes ☐ No

8. If the request is for the employee's medical condition, can the employee perform the essential functions of their position? (Please answer after discussing with the employee.) ☐ Yes ☐ No

9. Complete this portion only if the patient is the employee: If the employee cannot perform their position's essential functions, explain whether the employee can perform work of any kind and what activities the employee can perform.

10. If the leave is to care for the patient, explain the care the employee will provide and an estimate how long care will be needed.

11. Name of Physician or Practitioner (Please type or print)	12. Type of Practice (Specialization, if any)
13. Signature of Physician or Practitioner	14. Date
15. Address of Physician or Practitioner	16. Phone Number