CERTIFICATE OF PHYSICIAN OR PRACTITIONER

Name of Employee _____ EIN: _____

Period Under Professional Care	From (Month, Day, Year)	To (Monty, Day, Year)

DURING THIS ABSENCE PATIENT WAS INCAPACITATED FOR DUTY DUE TO:

_____ Illness or Injury

_____ Pregnancy and Confinement

_____ Care for a family member

_____ Contagious Disease

_____ Undergoing medical, dental or optical examination or treatment

Signature Date Address Telephone #

CERTIFICATE OF PHYSICIAN OR PRACTITIONER

Name of Employee _____ EIN: _____

Period Under Professional Care	From (Month, Day, Year)	To (Monty, Day, Year)

DURING THIS ABSENCE PATIENT WAS INCAPACITATED FOR DUTY DUE TO:

_____ Illness or Injury

_____ Pregnancy and Confinement

_____ Care for a family member

_____ Contagious Disease

_____ Undergoing medical, dental or optical examination or treatment

Signature Date Address Telephone #