SHARED LEAVE MEDICAL CERTIFICATE

Employee ______________________ Signature ______________________ Date __________

To: ATTENDING LICENSED PHYSICIAN/HEALTH CARE PRACTITIONER

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The signature of the employee above authorizes the release of information pertaining to their medical condition and expected duration.

1) Please describe the nature of the condition and its effect on the employee's ability to report to work.

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2) In your opinion, is the medical illness, injury, impairment, or physical or mental condition considered serious, extreme, or life-threatening? ☐ Yes ☐ No
3) Beginning date this condition has or will cause the employee to be absent from work: ___________
4) Expected duration of the absence: ______________________________
5) Shared leave use: ☐ Continuous ☐ Intermittent
6) Anticipated date employee will return to full-time employment with/without accommodation: ______

Licensed Physician/Health Care Practitioner ______________________ Signature ______________________ Date __________

Telephone ______________________

The contents of this document may be eligible for public disclosure. Social Security Numbers are considered confidential information and will be redacted in the event of such a request. This form is governed by Executive Order 16-01, RCW 42.56, and RCW 40.14.

Distribution: **ORIGINAL** - Employee Occupational Health Record