

MEDICAL STATEMENT

EMPLOYEE: DATE: _____

 ADDRESS: _____

 TELEPHONE: _____

I, AUTHORIZE MY PHYSICIAN TO DISCLOSE THE FOLLOWING INFORMATION TO MY EMPLOYER:

SIGNATURE _____ DATE: _____

FACILITY: NAME _____

 ADDRESS: _____

DATE DISABILITY BEGAN: _____

DIAGNOSIS: _____

EXPECTED DATE TO RETURN TO WORK: _____

COMMENTS _____

PHYSICIAN: NAME: _____

 ADDRESS: _____

 TELEPHONE: _____

 SIGNATURE: _____

 DATE _____