

Office of Human Resources
PO Box 6000
Binghamton, New York 139026000

Phone: (607) 772187
Fax (607) 774947

**CONFIDENTIAL MEDICAL STATEMENT
FOR WORK-RELATED DISABILITY**

Today's Date: _____

Patient:

Name (please print) _____

Address _____

Provider:

Name (please print) _____

Address _____

Brief statement of diagnosis _____

Date of treatment/office visit(s) _____

Date of accident _____

I certify that, in my medical opinion, this patient is disabled and unable to work

from _____ to _____

Anticipated date of return to regular duty is _____

I certify that, in my medical opinion, this patient is not disabled from the performance of his or her job

May Return to Work -No Longer Disabled _____

(date of return)

Signature of appropriate medical practitioner _____ Date: _____

Note: Rubber stamps and initialized signatures of practitioners are not acceptable.

I hereby release the above information to my employer Binghamton University.

Signature of Employee _____ Date _____