

**CITY OF ROCKVILLE CONFIDENTIAL  
MEDICAL CERTIFICATION FORM**

EMPLOYEE NAME: \_\_\_\_\_

DATE OF INJURY/ILLNESS: \_\_\_\_\_

**PHYSICIAN INFORMATION**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE #: \_\_\_\_\_ FAX#: \_\_\_\_\_

DATE(S) TREATED: \_\_\_\_\_

Can employee perform the duties of their job?     Yes                       No

If no, what activities can the employee perform and what are the employee's limitations?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When can employee return to full duty? \_\_\_\_\_

If employee cannot return to full duty, date of next evaluation? \_\_\_\_\_

Has employee reached Maximum Medical Improvement (MMI)?     Yes             No

**FOR JOB RELATED INJURY/ILLNESS OR DISABILITY ONLY**

Current diagnosis and prognosis: \_\_\_\_\_

As a duly licensed physician, I certify the above information.

Physician's Signature : \_\_\_\_\_ Date: \_\_\_\_\_