SUNY OSWEGO
Human Resources, 410 Culkin Hall
Oswego, New York 13126
Office: (315) 312 2215 FAX: (315) 312 6333

Confidential Medical Statement

For Work-Related Disability

I hereby release the information to my employer – SUNY OSWEGO

_____
Employee Signature Date

Patient Name:_____Date: _____

Address:
_____

Provider's Name: _____

Provider's Address:
_____

Date of Accident: _____

Brief statement of Diagnosis:

Dates of treatment/office visit(s):

I certify that in my medical opinion, this patient: ( ) is disabled ( ) is not disabled from the performance of his or her job. If disabled, the patient is unable to work from

_____to (anticipated) _____.

Date of return to regular duty: _____

_____
Signature of appropriate medical practitioner
(NOTE: Rubber stamps and initialized signatures of non-practitioners are not acceptable.