Medical Disability Certificate

Patient's name: _____

Date disability began
From:

Date disability ended/will end
To:

☐ Permanent disability

Date of hospitalization
From:

Date hospitalization ended
To:

Diagnosis:

Type of operation (if performed):

☐ **Patient may not return to work.**

☐ **Patient may return to working from home (telecommuting) on _____**

☐ **Patient may return to office work on _____**
with the following restrictions/accommodations: ☐ **None**

☐ Cannot lift or carry _____ pounds ☐ until _____ ☐ Permanent

☐ Requires walking aide: _____ ☐ until _____ ☐ Permanent

☐ Requires wheelchair ☐ until _____ ☐ Permanent

☐ While sitting, legs to be ☐ until _____ ☐ Permanent

☐ extended straight out ☐ extended straight down ☐ slightly angled ☐ knees may bend 90º

☐ Chair height max. _____ min. _____ ☐ until _____ ☐ Permanent

☐ Footrest height max. _____ min. _____ ☐ until _____ ☐ Permanent

☐ While swimming, legs must be ☐ until _____ ☐ Permanent

☐ straight ☐ knees can be bent

☐ Patient cannot ☐ until _____ ☐ Permanent

☐ drive ☐ walk ☐ run ☐ jog ☐ swim ☐ jump ☐ crawl ☐ bicycle ☐ ski

☐ no prolonged exposure to cold weather ☐ no overhead work with arms ☐ no prolonged sitting

☐ no squatting or deep knee bends ☐ no work on wet or slippery floors ☐ no prolonged standing

☐ Other:

Additional comments/explanations:

Handicapped parking:

☐ Temporary until _____ Type: _____

☐ Permanent

Physician's
signature: _____ Date: _____

Printed name: _____ E-mail: _____

Physician's address (street, city, state, zip code):