

MARYLAND CAPITOL POLICE
 Certificate of Illness or Disability
 Employee or Employee's Immediate Family Member

I. EMPLOYEE INFORMATION
(To be completed by the Employee)

Employee Name (Printed): _____ ID #: _____
 Employee Address: _____
 Rank/Class: _____ Assignment: _____
 Work Phone #: _____ Home Phone #: _____

| Date | # of Hours/Type |
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Leave Type: **A** = Adoption **AC** = Accident **C** = Child Birth **D** = Donated Leave **ESL** = Employee/Family Sick Leave
FMLA = Family and Medical Leave Act **LAW** = Medical Leave of Absence without pay

If recording FMLA, you must have completed an FMLA packet which has been approved by Human Resource Division.

I hereby authorize my health care provider(s) to release to the DGS Human Resource Division, all information regarding my current physical and/or mental health. The information contained within this form is true and correct to the best of my knowledge and belief.

Employee Signature: _____ Date: _____

II. SUPERVISOR'S CERTIFICATION
(To be completed by the Supervisor)

Are the above dates and hours certified by the employee's health care provider? Yes No (If no, return to employee)

Has the employee returned to work? Yes No If yes, date of return: _____

Full Duty or Approved Alternative Duty

NOTE: Alternative Duty request (Form 173) must be approved by the Deputy Chief of Police prior to employee returning to the workplace.

I have thoroughly reviewed this form for completion and compliance with Departmental policy and certify that the employee has sufficient accrued leave available to support their medical absence from the workplace. The employee has been made aware that he/she is responsible for submitting a completed original certificate of illness or disability to their Supervisor every 30 calendar days hereafter or upon return to the workplace, whichever is earliest, to maintain eligibility for their medical absence from work unless otherwise authorized in writing by the State Medical Director.

Supervisor's Signature: _____

Date Signed: _____ Phone #: _____

III. HEALTH CARE PROVIDER CERTIFICATION AND SIGNATURE
(To be completed by an authorized Health Care Provider)

Employee's Name (Printed): _____

Date of office visit: _____ Next scheduled office visit: _____

* Diagnosis: _____

***Must be completed if employee is applying for medical leave benefits available through the State of Maryland or the MCP, (i.e: Donated Leave, Worker's Compensation, Administrative/Accident Leave, or Alternative Duty, etc.)**

Prognosis: _____

Regimen of treatment, if any: _____

Section A: To be completed if absence is due to the employee's illness/injury. (Please complete all that apply)

Dates employee is/was unable to work in any capacity _____ to _____ (inclusive)

My current clinical impression is that employee will be able to return to **Alternative Duty** or **Full Duty** on _____
(Note: Alternative duty is defined as administrative desk duties)

Employee can return to work on Alternative duty from _____ to _____ (inclusive)

Restrictions: _____

Can employee safely operate an unmarked department vehicle? Yes No

Employee can return to full-duty with no restrictions on: _____

Was the employee's condition directly caused by his/her employment with the Maryland Capitol Police? Yes No
If yes, date of on-duty injury/illness: _____

Section B: To be completed if absence is due to the illness/injury of a member of the employee's immediate family

Immediate Family Member's Name: _____ Relationship: _____

Diagnosis: _____

Prognosis: _____

Regimen of treatment, if any: _____

Is employee needed to provide assistance for basic medical or personal needs, safety or transportation for an immediate family member with a serious health condition? Yes No

If yes, beginning and ending dates: _____ to _____ (inclusive)

I hereby certify I am a licensed medical practitioner and have satisfied and maintained the licensing requirements prescribed for my specialty. I further certify I have reviewed this patient's condition in a manner consistent with the prohibitions contained in regulations adopted by the State Board of Quality Assurance or its equivalent. My opinions are based on my personal review of the patient's examination and the conclusions reached are based on a reasonable degree of medical certainty. I understand the State Medical Director may contact me regarding the information certified herein.

Medical Practitioner's Signature: _____ Date: _____

Practitioner's Printed Name: _____ Specialty: _____

Office Telephone #: _____ Office Fax#: _____

Office Street Address: _____

City, State and Zip Code: _____