Alcorn State University Non-FML Medical Certification Form

HR use only:
☐ Approved ☐ Disapproved
Inclusive dates of leave with/without Pay:
_____ through _____
Employee information completed as attached?
☐ Yes ☐ No

I. TO BE COMPLETED BY EMPLOYEE:

Name: _____ Date: _____

Home Address: _____ A#: _____

Department: _____ Home Phone: _____

Job Title: _____

Brief Description of Duties: Position: ☐ Full-Time ☐ Part-Time

_____

_____

_____

Signature of Employee: _____

II. TO BE COMPLETED BY HEALTH CARE PROVIDER:

Name of Physician: _____ Date: _____

Address: _____ Telephone: _____

Projected duration of condition: _____ to _____
(Date disability is to start) (Projected date of return to work)

Brief Description of condition: _____

_____

_____

Date(s) you treated the patient for condition: _____

Is the employee unable to perform any of his/her job functions due to the condition? ☐ Yes ☐ No

If so, identify the job functions the employee is unable to perform: _____

_____

Describe any other relevant medical facts related to the condition for which the employee seeks leave (including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment.

_____

Signature of Health Care Provider: _____

Type of practice/medical specialty: _____

Please forward this completed form to the Department of Human Resources, 1000 ASU Drive 390, Lorman, MS 39096-7500.