

Office of Human Resources PO Box 6000 Binghamton, New York 13902-6000 Phone: (607) 777-2187 Fax (607) 777-4947

CONFIDENTIAL MEDICAL STATEMENT FOR WORK-RELATED DISABILITY

Today's Date:	
Patient:	
Name (please print)	
Address	
Provider:	
Name (please print)	
Address	
Brief statement of diagnosis	
Date of treatment/office visit(s)	
Date of accident	
************	**************
I certify that, in my medical opinion, this patient: is d	isabled and unable to work
from to	
Anticipated date of return to regular duty is	
************	**************
I certify that, in my medical opinion, this patient: is n	ot disabled from the performance of his or her job
May Return to Work – No Longer Disabled	
Signature of appropriate medical practitioner	(date of return) Date:
Note: Rubber stamps and initialized sign	natures of non-practitioners are not acceptable.
I hereby release the above information to my employ	ver Binghamton University.
Signature of Employee	Date