BINGHAMTON
UNIVERSITY
STATE UNIVERSITY OF NEW YORK

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 disabled and unable to work**

from _____ to _____

Anticipated date of return to regular duty is _____

****

I certify that, in my medical opinion, this patient: **is not disabled from the performance of his or her job**

May Return to Work – No Longer Disabled _____
(date of return)

Signature of appropriate medical practitioner _____ Date: _____

Note: Rubber stamps and initialized signatures of non-practitioners are not acceptable.

I hereby release the above information to my employer Binghamton University.

Signature of Employee _____ Date _____