

BINGHAMTON
UNIVERSITY
STATE UNIVERSITY OF NEW YORK

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**CONFIDENTIAL MEDICAL STATEMENT
FOR ORDINARY (NOT) 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) _____

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

Signature of Employee _____ Date _____

MEDICAL STATEMENT

****Provider complete all sections that apply ****

DISABLED FROM WORK: I certify that, in my medical opinion, this patient is disabled and unable to return to work from _____ to _____.

MAY RETURN TO WORK, NO LONGER DISABLED: I certify that, in my medical opinion, this patient is NOT disabled and may return to work without restrictions to perform his or her job as of (return to work date) _____.

Signature of appropriate medical practitioner _____ Date: _____

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