



# FIRE DEPARTMENT • CITY OF NEW YORK

## MEDICAL DOCUMENTATION FORM

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Title: \_\_\_\_\_

Shield (if applicable): \_\_\_\_\_ Bureau/Department: \_\_\_\_\_

Nature of Absence: \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

- This form is required for any sick leave usage, regardless of duration, for the absence to be considered documented.
- This form must be completed for illnesses, injuries, or medical appointments for employee absence exceeding three consecutive work days, or as directed by a supervisor, if sick leave with pay is to be approved.
- Failure to submit this form within five days of return to work deems the absence undocumented and may result in loss of pay and/or disciplinary action.
- Medical documentation may be subject to authentication and verification.

**THE FOLLOWING SECTION MUST BE COMPLETED IN ITS ENTIRETY BY THE HEALTHCARE PROVIDER/DIAGNOSTIC CENTER TO BE ACCEPTED AS OFFICIAL DOCUMENTATION.**

Health Care Provider/Diagnostic Center		Telephone No.
Address		
Physician/Facility Stamp	Provider's or Authorized Agent's Signature:	
	License/Registration No:	
	Date of Service:	
<b>COMPLETE IF PATIENT IS EMPLOYEE:</b>  I certify that _____  was seen on _____.  I further certify that employee was unable to perform his/her duties during the period from: _____ to _____.  Patient was advised that he/she is capable of returning to work on _____	<b>COMPLETE IF PATIENT IS FAMILY MEMBER:</b>  I certify that _____  was seen on _____.  Relationship to Employee: _____	
Nature of visit: (treatment/prognosis may be omitted when patient confidentiality is a consideration): _____ _____		

**THIS SECTION MUST BE COMPLETED BY THE UNIT SUPERVISOR**

Documentation Received: _____	Supervisor: _____
Date	Signature
Print Name	