

CITY OF JACKSONVILLE



CITY HALL, ST. JAMES BUILDING
117 WEST DUVAL STREET
JACKSONVILLE, FLORIDA 32202

MEDICAL CERTIFICATION PURSUANT TO FLORIDA STATUTE §112.1816

Employee Name: _____ **Date:** _____

Section I - to be completed by the Employer:

Employer Name and Contact: City of Jacksonville, Benefits Division
117 West Duval Street Suite 150, Jacksonville, FL 32202

Employee's job title: _____ **Check if job description is attached.**

Employee's regular work schedule: _____

Employee's essential job functions: _____

Section II- to be completed by the Health Care Provider:

Provider's Name and Business Address: _____

Telephone Number: _____ **Fax:** _____

Email Address: _____

Type of Practice/ Medical Specialty: _____

Has the employee ever been diagnosed with cancer prior to the current diagnosis: Yes No

If Yes, type of cancer: _____

Type of cancer the employee currently has: _____

Date of current cancer diagnosis: _____

Did you make this diagnosis? Yes No

Probable duration of the condition: _____

Use the information provided by the employer in Section I to answer this questions. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to his/her cancer diagnosis?

Yes No

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

Will the employee be incapacitated for a single continuous period of time due to his/her cancer diagnosis/treatment including any time for treatment and recovery? Yes No

If Yes, estimate the beginning and ending dates for the period of incapacity: _____

Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's cancer diagnosis and/or treatment? Yes No

Estimate treatment schedule, if any, including the dates of any scheduled appointment and the time required for each appointment, including any recovery period: _____

Estimate the part-time or reduced work schedule the employee needs, if any: _____

_____ hours per day; _____ days per week from _____ through _____

Will the cancer diagnosis and/or treatment periodically prevent the employee from performing his/her job functions? Yes No

Is it medically necessary for the employee to be absent from work during the flare-ups?
 Yes No

If Yes, please explain: _____

Based on the patient's medical history and your knowledge of the cancer diagnosis and/or treatment, estimate the frequency of the employee's periodic inability to perform his/her duties and the duration of related incapacity that the patient may have over the next 6 months:

Frequency: _____ time per _____ weeks _____ months

Duration: _____ hours or _____ days per episode

ADDITIONAL INFORMATION: _____

Signature of Health Care Provider

Date