

**MONTGOMERY COUNTY GOVERNMENT  
Medical Certification Form for Sick Leave or PTO Donations**

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**To be completed by physician or other licensed health care provider.**

**Date:** \_\_\_\_\_

**Employee/patient's name:** \_\_\_\_\_

**Employee/patient's job title:** \_\_\_\_\_

The above-named employee/patient is currently under my care. The employee/patient cannot perform the essential functions of the employee/patient's position with the Montgomery County Government because of the employee/patient's serious health condition, which may include complications of pregnancy or childbirth, or recovery from childbirth.

The employee/patient's serious health condition began on \_\_\_\_\_.  
*(Please provide date)*

I estimate that the patient will be able to return to work on \_\_\_\_\_.  
*(Please provide date)*

**Name of licensed health care provider:** \_\_\_\_\_  
*(Please print)*

**Professional title** \_\_\_\_\_  
*(medical doctor, licensed physical therapist, etc.)*

**Work phone:** \_\_\_\_\_

**Other phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

***Please return this form to the employee/patient.***