THE CITY UNIVERSITY OF NEW YORK
KINGSBOROUGH COMMUNITY COLLEGE

MEDICAL NOTE
(To be completed by attending physician)

EMPLOYEE'S NAME:_____ SS#_____

ADDRESS:_____TITLE:_____
(NUMBER & STREET)

_____DEPT:_____
(CITY STATE ZIP)

DATES OF ILLNESS:_____/_____
FROM TO

DATE OF FIRST TREATMENT:_____

DATE OF LAST TREATMENT: _ _____

COMPLETE DIAGNOSIS:_____

_____

POSITIVE PHYSICAL FINDINGS:_____

_____

MEDICATION: (If able to work at College while continuing medication)

_____/_____ _____
YES NO (If yes, name medication)

DATE MAY RETURN TO WORK AND ASSUME **FULL** JOB RESPONSIBILITIES:_____

(If not immediately, explain below for College review and records):_____

_____

_____

_____ _____
Physician's Signature Date

_____ (___)_____
Print Name Telephone # (including area code)

_____
Address Street & Number City State Zip

_____
New York State Registration Number

FOR COLLEGE REVIEW:

DATE POSTED TO RECORD: _____

FM1-2 (6/02)