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, c/o Mary DiPerna, 117 W. 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: _____ **Facsimile**: _____

Email Address: _____

Type of practice/Medical specialty: _____

Type of cancer employee currently has: _____

Date of cancer diagnosis: _____ **Did you make this diagnosis**? ☐ Yes ☐ No

Probable duration of condition: _____

Use the information provided by the employer in Section I to answer this question. 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 so, 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 so, 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 appointments and the time required for each appointment, including any recovery period: _____
_____

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

_____ **hour(s) per day**; _____ **day(s) 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 so, 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** _____ **week(s)** _____ **month(s)**

Duration: _____ **hours** or _____ **day(s) per episode**

ADDITIONAL INFORMATION: _____

_____

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider Date