

**Pittsburg State University
Health Care Provider Statement**

When completing forms, please write legibly and be clear and thorough with explanations.

Employee Name: _____ Department: _____

Part I: To be completed by the patient's Licensed Health Care Provider

Patient's Name: _____

Date first consulted for this condition: _____

Describe the **nature** of the illness, injury, impairment or physical or mental condition (please attach documentation):

Describe the **diagnosis** of the illness, injury, impairment or physical or mental condition (please attach documentation):

Describe the **treatment and prognosis** of the illness, injury, impairment or physical or mental condition (please attach documentation):

Anticipated duration the patient will be unable to work due to the condition:

From: _____ Through: _____

Dates of hospitalization (if applicable): From: _____ Through: _____

Date of Surgery (if applicable): _____

Physician Name: _____ Telephone #: _____

Address: _____

City

State

Zip

Licensed Health Care Signature

Date