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
If this request is for the care of a family member please indicate the roll they will have in the care.

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):

If this request is for the care of a family member, please indicate **the role they will have in the care**.

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 Provider Signature Date