

**Certifying Licensed Physician or Primary Health Care Provider qualified in
the appropriate specialty area.**

(Must be completed by a licensed practitioner)

Name: (Last, First, M.I.) _____

Medical Facility: _____

Address _____

City _____

State: _____ ZIP: _____ Phone: _____

License no: _____ Specialty: _____

Signature: _____ Date: _____

I hereby certify that the information contained herein is true and accurate to the best of my knowledge.

For general questions pertaining to information requested, please contact the Employment
Accommodations Resource Center at 408-924-6003.