# Saginaw Valley State University
## Certification of Medical Condition

**Employee's Name:** _____ Department: _____

Home Address/Street: _____ City: _____ State: _____ Zip: _____

**TO BE COMPLETED BY THE EMPLOYEE'S PHYSICIAN/PRACTITIONER:**
**(Please Print)**

Nature of Illness or Injury:

_____

_____

_____

_____

To the best of my knowledge the Employee/Patient is adhering to a prescribed treatment plan: ☐ Yes ☐ No

The Employee/Patient is able to work commencing: _____

The Employee/Patient is able to work with the following restrictions: _____

_____

Physician's Signature: _____

Physician's Name: (Please Print) _____

Phone Number: (_____) _____ Date of Latest Evaluation: _____

Please return to: Human Resources Office
Saginaw Valley State University
7400 Bay Road
University Center, MI 48710
Fax: 989-790-7066