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: ____

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Section II – to be completed by the Health Care Provider:

Provider's name and business address: ____

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Telephone number: ___________________________ **Facsimile:** _______________________

Email Address: ____

Type of practice/Medical specialty: ____

Has the employee being previously diagnosed with cancer? ☐ Yes ☐ No **Type of cancer:** __________

____

Type of cancer employee currently has: ____

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

Probable duration of condition: ____

Does the employee have a history of cancer? (Please mark yes if you have knowledge of occurrence but diagnosis was made by another physician) ☐ Yes ☐ No **Type of cancer:** ___________________

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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: _____________________

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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: ___________________________

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

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_______ **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: ____
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_____________________________________ ____________________
Signature of Health Care Provider Date