Harvard T.H. Chan School of Public Health
Office of Faculty Affairs

MEDICAL LEAVE FORM, NON-MATERNITY

For Research Scientists, Research Associates, Instructors, and Visiting Scientists

SECTION I: To be completed by EMPLOYEE

Last Name: _____ First Name: _____

Harvard I.D. #: _____ Email address: _____

Address _____ Home telephone: _____

City _____ State ____ Zip Code _____

Years of Harvard employment:

◯ Less than 7 years ◯ More than 7 years

Appointee Signature, Date

Administrator Signature, Date

SECTION II: To be completed by HEALTH CARE PROVIDER (required)

Date first seen in your office in this condition _____ Date of onset of disability _____

Is surgery expected? If yes, give date: _____

Is illness chronic? ◯ yes ◯ no

Is disability related to work activities? ◯ yes ◯ no

Is illness/injury acute? ◯ yes ◯ no

If yes, what has led to disability at this time:

Is employee being treated by any other physician[s]? ◯ yes ◯ no

If yes, please provide name, address and specialty:

Is employee compliant with treatment recommendations?

Expected duration of incapacity (Please note that re-certification will be required at least every 60 days):

Is a return to work on a reduced work schedule or modified work duties appropriate at this time? ◯ yes ◯ no

Will one of those options become appropriate within the next 60 days? ◯ yes ◯ no

Expected date of return to work

Name of Health Care Provider: Phone Number

Type of Practice MA License Number

Provider Signature Date