MASSACHUSETTS DEPARTMENT OF CORRECTION
ILLNESS CERTIFICATION FORM

FAMILY ILLNESS

TO BE COMPLETED BY MEDICAL PROVIDER (Additional information may be attached)

Medical Provider (print name): _____

Licensed Profession (circle one):
licensed physician
physician's assistant
nurse practitioner
chiropractor
dentist

Address:_____

Phone Number: _____

Employee's Name: _____

Patient's Name and Relationship to Employee:_____

The patient has been determined by me to be seriously ill, or the appointment with the licensed medical or dental professional could not reasonably be scheduled outside of normal working hours for purposes of medical treatment or diagnosis of an existing medical or dental condition, and in need of care on _____.
(Date)

_____ _____
Signature of Medical Provider* Date

(*If a signature stamp is used, it must be accompanied by the initials of someone authorized to do so.)