

THE CITY UNIVERSITY OF NEW YORK  
KINGSBOROUGH COMMUNITY COLLEGE

MEDICAL NOTE

(To be completed by attending physician)

EMPLOYEE'S NAME: \_\_\_\_\_ SS# \_\_\_\_\_

ADDRESS: \_\_\_\_\_ TITLE: \_\_\_\_\_  
(NUMBER & STREET)

DEPT: \_\_\_\_\_  
(CITY STATE ZIP)

DATES OF ILLNESS: \_\_\_\_\_ / \_\_\_\_\_  
FROM TO

DATE OF FIRST TREATMENT: \_\_\_\_\_

DATE OF LAST TREATMENT: \_\_\_\_\_

COMPLETE DIAGNOSIS: \_\_\_\_\_

POSITIVE PHYSICAL FINDINGS: \_\_\_\_\_

MEDICATION: (If able to work at College while continuing medication)

\_\_\_\_\_/\_\_\_\_\_  
YES NO (If yes, name medication)

DATE MAY RETURN TO WORK AND ASSUME **FULL** JOB RESPONSIBILITIES: \_\_\_\_\_ (If not immediately, explain below for College review and records): \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

(\_\_\_\_\_) \_\_\_\_\_  
Telephone # (including area code)

\_\_\_\_\_  
Address Street & Number City State Zip

\_\_\_\_\_  
New York State Registration Number

FOR COLLEGE REVIEW:

DATE POSTED TO RECORD: \_\_\_\_\_