

ABSENCE CERTIFICATE
United Medical

Co-workers must schedule medical appointments outside of work hours; medical care that is not available outside the co-worker's work hours must be documented and scheduled at the beginning or end of their shift. Job Descriptions available through your supervisor and in the Flying Together website.

CO-WORKER: _____ ID NUMBER: _____ DEPT CODE: _____

**To Be Completed by Health Care Provider
upon review of the job description**

- ABLE TO RETURN TO FULL DUTY WITHOUT WORK RESTRICTIONS: ____/____/____
- ABLE TO WORK WITH RESTRICTIONS WORK FROM: ____/____/____ to ____/____/____
- UNABLE TO WORK FROM: ____/____/____ to ____/____/____

MEDICAL FACTS SUPPORTING THE NEED TO BE OFF WORK (describe specific job duties unable to perform): *For CA employees, this section is optional, do not disclose the underlying diagnosis on this form without consent from the co-worker.*

GENERAL TREATMENT PLAN:

PROGRESS OF TREATMENT:

SPECIFIC WORK RESTRICTIONS AND ESTIMATED DURATION (i.e. 50 lb. lifting limit, no typing, maximum of 4 hrs. standing, etc.):

PAST OFFICE VISITS FOR CONDITION: ____/____/____; ____/____/____; ____/____/____; ____/____/____

NEXT APPOINTMENT: ____/____/____

HEALTH CARE PROVIDER (HCP) INFORMATION:

PRINTED NAME: _____ TYPE OF PRACTICE: _____

ADDRESS: _____ CITY: _____ STATE: _____

PHONE NUMBER: (____) _____-_____ FAX NUMBER: (____) _____-_____

HCP'S SIGNATURE: _____ DATE: ____/____/____

Please fax the completed document to United Medical: (847) 700-2600

If you have any questions, please contact the Employee Service Center: 1-877-UAL-ESC9

To comply with the Genetic Information Nondiscrimination Act (GINA), do not provide any genetic information (family medical history, sought or received genetic services, results of genetic tests, genetic information of a fetus/ embryo) when completing this form.