

INTERNIST ASSOCIATES OF CENTRAL NEW YORK, PC

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Suite 100
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Certification of Health Care Provider

Employee's Name: _____ DOB: _____

Patient's Name: _____ DOB: _____
(If different from the Employee)

To whom it may concern:

The aforementioned employee requesting certification that (s)he has been or is being treated for a medical condition by a provider in this office. The form is intended and is to substitute any employer-specific or OMB Form WH-380 for the purposes of demonstrating a medical certification. This is the only form an Internist Associates of Central New York provider can complete in this regard.

Date(s) of Service for the patient:

Description of medical facts relating to patient:

Date(s) employee should be excused from work to care for patient or to be cared for him/herself:

(If none, write in "none")

Date, if any, patient is scheduled to return for follow-up:

(if blank, no follow-up appointment date is scheduled)

Certifying Provider Signature

Date of Certification

Certifying Provider Name (Please Print)

Paul Kronenberg, MD Ray Forbes, MD James Blanchfield, MD Eileen Stone, MD Anne Bishop, MD Louis Green, MD
Erik Daly, MD Ami Milton, MD Caroline Keib, MD Carl Butch, MD Seth Kronenberg, MD Barbara Clayton, MD
Stephan Alkins, MD Nanette Sable, MD Rachna Zirath, MD Ayesha Aziz, MD Mark Erlebacher, MD Karen Heitzman, MD
J. Kurt Concilla, DPM Jennifer Sohl, RNNP Lori Dana, RNNP Deborah Schu, RNNP Margaret Ann Sitnik, RNNP
Bridget Miller, RPA Kathleen Anderson, RNNP Linda Halko, RNNP E. Kristin Cominsky, RNNP