ATTENDING PHYSICIAN'S CERTIFICATE FOR MEDICAL LEAVE

Instructions: This form is to be used along with a Request for Leave of Absence form by any employee requesting a medical leave of absence. Completion of this form by the employee's physician and its return to the Human Resources Department is the employee's responsibility. A medical leave of absence cannot be approved until this completed form is received by TeleTech's Human Resources Department.

PART ONE: *To Be Completed By The Employee*

Employee Name: _____ Employee Number: _____ SSN: _____

Project/Department:_____ Title: _____ Location _____

Supervisor/Manager: _____ Date of Hire _____

Current Address:

_____

Street City State Zip

Telephone Number: ( ) _____ Last Day Worked: _____

I authorize my physician to release to TeleTech or its authorized agent(s) any and all necessary information, including medical records, medical history, diagnosis, treatment, and prognosis concerning the illness or injury for which I am now requesting a medical leave of absence. This authorization shall remain in effect for the duration of this leave of absence and any extension thereof.

Employee Signature: _____ Date: _____

PART TWO: *To Be Completed By Attending Physician*

Note to Physician: TeleTech's policy requires its employees to provide medical certification when requesting a medical leave of absence. Your cooperation in furnishing the requested information will assist TeleTech in determining whether to grant a medical leave of absence to this employee. Please complete this form and return it within five (5) working days to TeleTech's Human Resources Department at the above address. If you have questions, please direct them to the Human Resources Department at (303) 894-4104.

Date Present Illness or Injury Began: _____ Date Patient First Examined for this Condition: _____

Date of Most Recent Examination: _____ Date of Next Scheduled Examination: _____

Date of Surgery (if applicable): _____

DIAGNOSIS: _____

PROGNOSIS: _____

PRESCRIBED TREATMENT: _____

EXPECTED DATE OF RETURN TO WORK: _____

Physician's Signature: _____ Date: _____

Physician's Name:_____ Telephone Number: _____

Address: _____

Street City State Zip

Routing: Human Resources Confidential Medical File only Rev. 1/99