CERTIFICATION OF MEDICAL PROFESSIONAL
RELATING TO
PRE-EXISTING CONDITIONS AND COVID-19

Name of Employee: _____
Provider's name and business address: _____
Telephone: _____ FAX: _____
Type of practice / Medical specialty: _____

1. I, the above-named Medical Professional, am responsible for the medical treatment of the above-named Sussex County employee ("Employee").

2. I am a medical professional licensed in the State of New Jersey, and I hereby submit this Certification of Medical Professional to certify that it is unsafe for the Employee to work at his/her worksite while New Jersey is in a State of Emergency due to COVID-19 pandemic.

3. I am fully aware of the Employee's medical condition based upon (i) my medical treatment of the Employee, and (ii) information provided as the Employee's treating medical professional.

4. I am fully aware of the current COVID-19 (coronavirus) pandemic, and of the various statements by the Centers for Disease Control and Prevention (CDC) related to the fact that individuals with certain pre-existing conditions are particularly at risk of serious illness or death if they contract the COVID-19 virus.

5. Will the employee be incapacitated for a single continuous period of time? __NO __YES
    a. If so, estimated the beginning and ending date for the period of incapacity: _____

6. Is the employee unable to perform any of his/her job functions due to the medical condition: __NO __YES
    a. If so, identify the job functions the employee is unable to perform:

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7. Can the employee work on an intermittent, part-time and/or reduced work schedule based upon the medical condition?

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8. It is my professional medical opinion that the Employee's _____

_____ (condition) is a pre-existing condition that deems him/her to be at high risk of serious illness or death if they contract the COVID-19 virus.

I hereby certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

_____
Signature of Medical Professional

Date: _____