

This form is used by ExxonMobil to document medical absences due to illness or injury, support access to benefits and assist employees returning to work. This form is used to document two main types of absences:

- Simple and short (not requiring active case management by ExxonMobil’s Medicine and Occupational Health (MOH) team) – Certification of Care form
- Longer term or requiring work limitations (active case management by MOH)– Individual Disability Report (IDR) Form

The information provided will be used to determine eligibility for company provided disability benefits and to determine the person’s physical and mental ability to safely perform the duties of the job. ExxonMobil reserves the right to request a full IDR for all medical absences.

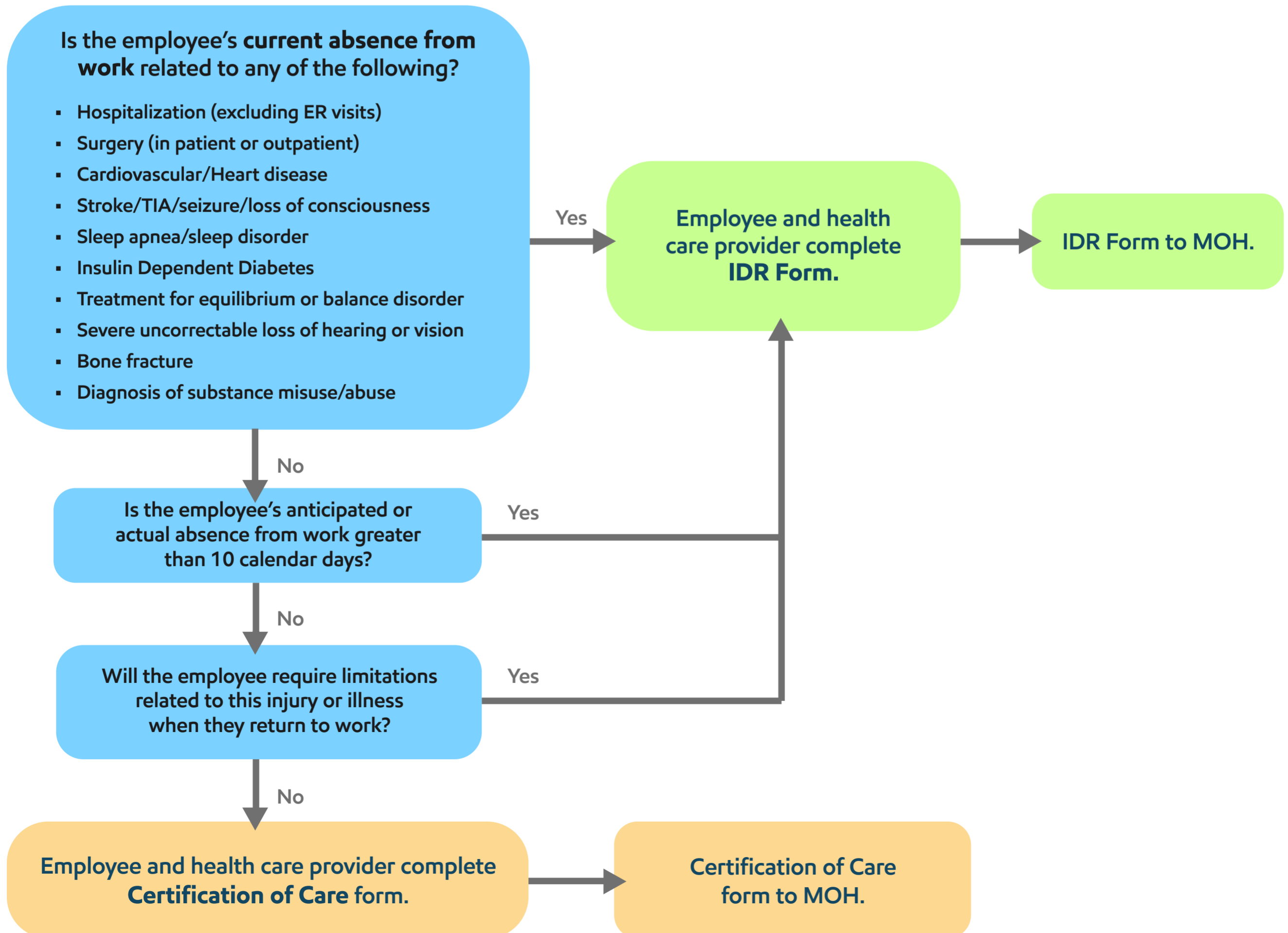
Instructions for the ill or injured employee:

- Follow applicable reporting guidelines established by your worksite.
- Use the flow chart to determine the correct form (Certification of Care or IDR Form).
- Complete the section under “Employee completes...” and provide to your health care provider. We recommend printing this form and bringing it to your next appointment.
- If your doctor’s office charges a fee to complete this form, payment is your responsibility. It is not reimbursable or covered by insurance.
- An appropriate doctor’s note in lieu of certification of care may be acceptable at the discretion of MOH.
- You do not need to disclose any medical information to your supervisor.

Instructions for health care provider:

- Please complete the appropriate form and provide to your patient or ExxonMobil’s MOH.
- Do not include any genetic information.

Any employee involved in the Medical Certification (MedCert) program should discuss with their supervisor as their process will be different.





Certification of Care

MOH Contact Email

MOH Fax Number

Find your MOH Contact at: [Goto/MOHlocations](#) via the intranet or [ExxonMobilFamily.com](#) via the internet

Employee Completes 1.

Instructions for the **employee**:

- Bring a printed copy to your next appointment.
- Once complete, provide to MOH.

Employee Name

Employee Personal Email

Employee Personal Cell Number

Supervisor Name

Last date employee was at work

Date of first day missed work

Health Care Provider Completes 2.

Instructions for **health care provider**:

- Please do not include any medical information on this form.
- The completed form can be given back to your patient.
- **This is not the correct form for employees requiring work limitations. Please complete the full IDR form if necessary.**

Employee may return to work without limitations on this date:

I have examined this patient on this date:

Doctor/Provider Signature

Printed Name

Practice Name

Practice Phone Number



IDR Form

MOH Contact Email

MOH Fax Number

Find your MOH Contact at: [Goto/MOHlocations](#) via the intranet or [ExxonMobilFamily.com](#) via the internet

Employee Completes 1.

Employee Name

Supervisor Name

Employee Personal Email

Last date employee was at work

Employee Personal Cell Number

Date of first day missed work

Medical release of information:

My signature authorizes my medical provider to release all medical information related to my current medical condition for a period of one year to the ExxonMobil Disability Plan and to ExxonMobil Medicine and Occupational Health (MOH) to be used in evaluating my ability to work, including work limitations where appropriate.

I understand that any work limitations established will be communicated to my management to determine whether I can return to work with those limitations with or without accommodations. I also authorize the use of this information to determine my eligibility for benefits under the ExxonMobil Disability Plan. I understand that I can prospectively revoke this release by providing written notice to MOH.

Signature

Date

My job role includes the following duties. [Check all that apply]

- Climb structures/ladders
- Climb stairs routinely
- Climb/descend stairs in an emergency
- Drive heavy equipment
- Drive a vehicle (excluding commute)
- Work at heights
- Work around moving machinery
- Work overhead
- Kneel/crawl
- Bend/stoop/squat
- Lift/push/pull/carry up to lbs.
- Type and use a computer
- Work alone without anyone around > 1hr
- Other physical activity

Health Care Provider Completes 2.

Instructions for Health Care Provider

Please review the information provided by your patient above. Do not include any genetic information on this form. If recommending work limitations, please be specific (e.g.: Do not lift more than 15 lbs.). Avoid vague statements (e.g.: Light duty). The completed form can be given back to your patient or sent directly to ExxonMobil's MOH using the contact details in the top right.

I have examined the patient on this date

Date of patient's next appointment

Diagnosis

Treatment Plan

Select one of the following:

- At this time, employee is unfit for any type of work. I anticipate employee will remain unfit until [date]:
- I have discussed work duties with the employee. At this time, employee may return to work with limitations. I anticipate employee will require these limitations until [date]:

Please list limitations based on medical diagnosis...

If applicable:

Date of surgery:

Date of discharge:

If pregnancy:

Date of delivery:

- Employee may return to work without limitations on [date]:

Doctor/Provider Signature

Practice Name

Practice Phone Number

Printed Name and Credentials

Practice E-mail Address

Practice Fax Number