Leave of Absence - Certification of Health Care Provider for Employee's Serious Health Condition

Employee Name_____

Department_____

INSTRUCTIONS to the HEALTH CARE PROVIDER. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's Name and Business Address:_____

Type of Practice / Medical Specialty:_____

Telephone:_____Fax:_____

PART A: MEDICAL FACTS

Approximate date condition commenced:_____

Probable duration of condition:_____

Mark below as applicable:
Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ___No ___ Yes. If so, dates of admission:
_____

Date(s) you treated the patient for condition:
_____
Will the patient need to have treatment visits at least twice per year due to the condition?
___No ___ Yes.

Was medication, other than over-the-counter medication, prescribed? ___No ___Yes

Was the patient referred to another health care provider(s) for evaluation or treatment (e.g., physical therapist)? ____No ____Yes.

If so, state the nature of such treatments and expected duration of treatment:
_____

Is the medical condition pregnancy? ___No ___Yes.
If so, expected delivery date: _____

Use the information provided by the employer to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition:
____ No ____ Yes.
If so, identify the job functions the employee is unable to perform:

Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):
_____
_____
_____
_____
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_____
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PART B: AMOUNT OF LEAVE NEEDED

Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ___Yes.
If so, estimate the beginning and ending dates for the period of incapacity: _____

Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___No ___Yes.
If so, are the treatments or the reduced number of hours of work medically necessary? ___No ___Yes.
Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:
_____

Estimate the part-time or reduced work schedule the employee needs, if any: _____ hour(s) per day; _____ days per week from _____ through _____

Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____No ____Yes. Is it medically necessary for the employee to be absent from work during the flare-ups? ____ No ____ Yes .
If so, explain: Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days): Frequency: _____ times per _____ week(s) _____ month(s) Duration: _____ hours or ___ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER

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_____ _____

Signature of Health Care Provider Date