MEDICAL CERTIFICATION FOR SICK AND/OR FMLA-COVERED LEAVE

The purpose of this form is to obtain certification for sick leave and/or other leave covered by the FMLA (with or without pay) for the employee named below. Approximate dates of absence and return <u>are required</u> for this employee to be granted leave. "Open-ended" certifications cannot be accepted.

<u>Instructions to Health Care Provider</u>: Please complete sections C and E and, if appropriate, the supplement to Section B. If this request relates to the employee's own illness/injury, a description of the employee's duties is provided in Section B.

<u>SECTION A</u>: Demographic Information *(to be completed by employee)*

Employee Name_____ Title_____

Unit_____ Home Phone_____ Address_____

Patient's Name (if other than Employee)_____ Relationship_____

<u>SECTION B</u>: Brief Description of Employee Job Duties *(to be completed by Supervisor or Employee if absence is due to the Employee's medical condition).*

Check here ( ) if supplemental sheet is attached.

<u>SECTION C</u>: Required Care

Date patient became incapacitated from work/school/daily activities: _____

Date patient is anticipated to no longer be incapacitated: _____

Did this condition result in in-patient hospitalization (i.e., an overnight stay)? **( )YES ( )NO**

Describe regimen of treatment prescribed by indicating number of visits, general nature and duration of treatment, including referral to other provider of healths services.

Answer the following questions if the certification relates to care for the employee's own serious illness.

If this condition makes it medically necessary for the employee to be off work on an intermittent basis or to work less than his/her normal work schedule, indicate the reduction in hours per day/week

What duties of his/her position is the employee unable to perform because of the serious health condition? Indicate any accommodations which would enable the employee to perform these functions without posing a significant risk of injury to the employee or to others.

Is employee unable to perform work of any kind because of a serious health condition? **( )YES ( )NO**

Answer the following if this certification relates to care for the employee's seriously ill family member.

After review of the employee's statement in Section E below, is the employee's presence necessary or would it be beneficial for care of the patient (may include psychological comfort)? **( )YES ( )NO**

Estimate the period of time care is needed or the employee's presence would be beneficial. If it is medically necessary for the employee to take leave on an intermittent or reduced schedule, please specify.

SECTION D: Release to Return to Work *(to be completed by health care provider, if applicable)*

Approximate Period/Dates of Absence for Medical Reasons: From_____ To_____

This employee is released to return to work on _____. Restrictions on work duties, if any, are as follow:

SECTION E: Statement by Employee Needing Family Leave
(to be completed by the Employee if the leave is for a family member)

Please state the care you will provide and an estimate of the applicable time period, including a schedule of care if leave is to be taken intermittently or on a reduced leave schedule. Please also state to what extent, if any, you will be engaged in other employment during the leave and the schedule of such employment.

SECTION F: Health Care Provider's Signature

I certify that I am a health care provider for the patient described above. As appropriate, I have reviewed the statements in Section B (for leave due to the employee's personal serious illness) or those in Section D (for leave to care for a family member) and have completed this form based on that information and my evaulation of the patient's medical condition.

_____ Address_____
Health Care Provider Signature Date

_____

Type Practice (including speciality, if any)_____

Telephone_____

_____

Supplement to Medical Certification Form

SUPPLEMENT TO SECTION B: Description of Employee Job Duties

The employee's supervisor must list each of the employee's essential job duties in Column 1.
For each duty, the health care provider must complete Columns 2 and 3.

(1) List of Essential Duties *(TO BE COMPLETED BY SUPERVISOR)*	*TO BE COMPLETED BY HEALTH CARE PROVIDER*	
	(2) State whether employee may perform this duty	**(3) State any accommodation which would allow the employee to perform this duty.**

When can this employee return to "light duty" work such as desk jobs for report writing, data evaluation, computer work, etc.

( )1 week ( )2 weeks ( )3 weeks ( )More than 3 weeks - please explain below.

Note to Supervisors: For positions requiring physical exertion, please be specific in terms of describing weights and frequency.

02/00