Certification of Health Care Provider for Employee's Serious Health Condition (Personal Medical non FMLA Leave)

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: Employees requesting a Personal Medical leave of absence because of a need for leave due to a serious health condition are required submit a medical certification issued by the employee's health care provider.

Employer name and contact: ____

Employee's job title: ____________________________________ Regular work schedule: ________________________

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. It is required to submit a timely, complete, and sufficient medical certification to support a request for Personal Medical leave due to your own serious health condition. Failure to provide a complete and sufficient medical certification may result in a denial of your request. **It is your responsibility to ensure that the health care provider returns the completed form to you or Employee Health 205.975.6900 within 15 calendar days of receipt.**

Your name: ____

First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested a leave of absence. 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 to determine coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, genetic services, or the manifestation of disease or disorder in the employee's family members. 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

1. 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 other 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:

   ____

   ____

2. Is the medical condition pregnancy? _____ No _____ Yes If so, expected delivery date: ________________________________

3. Answer the following questions based upon the employee's 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: ____

4. 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):

____

____

PART B: AMOUNT OF LEAVE NEEDED

5. 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: From:_________________ To:__________________

6. 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 _______________

7. 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)

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

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____ ________________________________

Signature of Health Care Provider **Date**