

Certification of Health Care Provider

Revised 08/30/13

1. Employee's Name: _____
2. Patient's Name/Relationship (if different from employee :) _____
3. Into which category or categories does the patient's condition fall? (Please check all that apply)
 - (1) Inpatient Hospital Care _____
 - (2) Absence plus Treatment _____
 - (3) Pregnancy _____
 - (4) Chronic Conditions Requiring Treatments _____
 - (5) Permanent/Long-term Conditions Requiring Supervision _____
 - (6) Multiple Treatments (Non-Chronic Conditions) _____
- 4 (a) State the approximate date the condition commenced and the probable duration of the condition of the patient's present incapacity, if different: _____
- (b) Will it be necessary for the employee to work only intermittently or to work on a less than full schedule as a result of the condition, including for treatment described in Item 6 below? _____
 If yes, give the probable duration: _____
- (c) If the condition is a chronic condition or pregnancy, please state whether the patient is presently incapacitated and the likely duration of and/or frequency of episodes of incapacity _____

5. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments: _____

 If the patient will be absent from work or other daily activities because of treatment on an intermittent or part-time basis, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any: _____

6. If regimen of continuing treatment by the patient is required under your supervision, provide a **general** description of such regimen (i.e., prescription drugs, physical therapy requiring special equipment): _____

7. If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), please state whether the employee unable to perform work of any kind? _____

A. For *Physician* to complete:_____
(Please Print) Name of Health Care Provider_____
Signature of Health Care Provider_____
Address_____
Telephone Number_____
Type of Practice_____
Date**B. For *Employee* to complete:**_____
Employee Signature_____
Date