Howard County Public School System

Healthcare Provider Certification Form

For Continuous Leave

Note: The information sought on this form pertains only to the condition for which the employee is requesting leave.

Part A. To be completed by the Employee

Employee name_____ Employee number_____

Patient name (if not employee)_____ Relation to employee_____

I hereby authorize the undersigned healthcare provider to release information required to verify my request for a leave of absence. If sufficient information is not provided, I understand that it may be necessary to submit additional information upon request.

Employee Signature_____ Date_____(mm/dd/yyyy)

Part B. To be completed by the healthcare provider

Physician/Practitioner name_____ Specialization/Type of practice_____

Address_____ Phone_____

Part B1. Medical Information

Check the box(es) as applicable:

For <u>all cases</u>, briefly describe appropriate medical facts related to the condition(s), including prognosis and diagnosis.

_____

_____

☐ **Pregnancy:** The condition is pregnancy. List the expected delivery date: _____ (mm/dd/yyyy).

☐ **Inpatient Care / Incapacity plus Treatment:** The patient (has been / is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility. Or the patient requires outpatient surgery, strep throat, etc.

☐ **Permanent or Long-Term Conditions:** Due to the condition, incapacity is permanent or long-term and requires the continuing supervision of a healthcare provider (even if active treatment is not being provided).

☐ **Other**: Please provide medical information _____

Part B2. Amount of Leave Needed

Your answer should be your best estimate. Be as specific as you can; terms such as "lifetime", "unknown", or "indeterminate" may not be sufficient to approve the leave request. A date is required to be provided.

Provide your **best estimate** of the beginning date _____ (mm/dd/yyyy) and end date _____ (mm/dd/yyyy) for the period of continuous incapacity. (These dates should be the dates that the patient is not able to continuously be at work).

Part B3. Return to Work – Restrictions and/or Accommodations

(Only to be completed if the patient is the employee).

Are restrictions and/or accommodations needed when the employee returns to work ☐ Yes ☐ No

If no, the return date to full duty, without restrictions and/or accommodations is_____ (mm/dd/yyyy)

If yes, are the restrictions and/or accommodations known at this time? ☐ Yes ☐ No

If no, the employee will need to provide updated medical documentation before returning to work.

If yes, please list any restrictions and/or accommodations and the end date of restrictions: _____

_____Restrictions end date _____ (mm/dd/yyyy)

Part B4. Healthcare Provider Signature

Signature of Healthcare Provider_____ Date_____(mm/dd/yyyy)

Part C. Return Form

Return completed form to **HCPSS** via: Secure fax 410-680-3427 or Email HRLeaveofAbsence@hcpss.org