Healthcare Provider Certification Form

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

____

____

☐ **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.

☐ **Chronic Conditions / Conditions requiring Multiple Treatments / Permanent or Long-Term Conditions:** Due to the condition, it is medically necessary for the patient to receive multiple treatments or treatment visits at least twice per year or is 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.

Provide your **best estimate** of the beginning date ___________ (mm/dd/yyyy) and end date _____________ (mm/dd/yyyy) for the period of incapacity.

1. Due to the condition, the patient (had / will have) **planned medical treatment(s)** (scheduled medical visits) on the following date(s):
   ____
2. Due to this condition, it is medically necessary for the employee to work a **reduced schedule**. Provide your best estimate of the reduced schedule the employee can work. The employee can work (e.g. 5 hours/day, up to 25 hours a week) ___________
   ____
3. Due to this condition, it is medically necessary for the employee to be absent from work on an intermittent basis (periodically). Provide your best estimate, during the leave, that the **episodes of incapacity** are estimated to occur _________________times per (☐ day ☐ week ☐ month) and are likely to last approximately ___________________ (☐ hours ☐ days) per episode.

Part B3. Essential Job Functions

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

Due to this condition, the employee is able to work without restrictions: ☐ Yes ☐ No If no, please list any restrictions 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