Diocese of Sacramento — Human Resources Services

MEDICAL / FAMILY LEAVE — MEDICAL CERTIFICATION FORM
FOR SERIOUS HEALTH CONDITION OF FAMILY MEMBER

Employee name: _____

Employer name and contact: _____

Employee's job title: _____

Employee's regular work schedule: _____

NOTICE TO THE EMPLOYEE: The medical/family leave policy of the Parish/School/Diocese requires that you submit a timely, complete, and sufficient medical certification to support a request for medical/family leave to care for a family member with a serious health condition and your response is required to obtain or retain the benefit of the policy. Failure to provide a complete and sufficient medical certification may result in denial of your medical/family leave request. Your leave is "pended" (awaiting approval) until the Parish/School/Diocese receives the required medical certification.

Name of family member for whom you will provide care: _____

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____

FOR COMPLETION BY THE HEALTH CARE PROVIDER

Instructions To The Health Care Provider: The employee listed above has requested leave under the medical/family leave policy of the referenced Parish/School/Diocese, to care for your patient. Please answer, fully and completely, all the applicable parts below. 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 under the policy. Please limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page. Thank you.

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. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

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PART B: AMOUNT OF CARE NEEDED

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? _____ No _____ Yes

   If so, estimate the beginning and ending dates for the period of incapacity: _____

   _____

   During this time, will the patient need care? _____ No _____ Yes

   Explain the care needed by the patient and why such care is medically necessary: _____

   _____

   _____

   _____

   _____

5. Will the patient require follow-up treatments, including any time for recover? _____ 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:

   _____

   Explain the care needed by the patient, and why such care is medically necessary: _____

   _____

   _____

   _____

   _____

6. Will the patient require care on an intermittent or reduced-schedule basis, including any time for recovery? _____ No _____Yes

   Estimate the hours the patient needs care on an intermittent basis, if any:

   _____ hour(s) per day; _____ days per week — from _____ through _____

   Explain the care needed by the patient, and why such care is medically necessary: _____

   _____

   _____

   _____

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? _____ No _____Yes

   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) per episode

   Does the patient need care during these flare-ups? _____ No _____Yes

   Explain the care needed by the patient, and why such care is medically necessary: _____

   _____

   _____

   _____

   _____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

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_____ _____

Signature of Health Care Provider **Date**

_____

Printed Name of Health Care Provider