Diocese of Sacramento — Human Resources Services

MEDICAL / FAMILY LEAVE — MEDICAL CERTIFICATION FORM
FOR EMPLOYEE'S SERIOUS HEALTH CONDITION

Employee name: _____

Employer name and contact: _____

Employee's job title: _____

Employee's regular work schedule: _____

Employee's essential job functions: _____

Check if job description is attached: _____

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 due to your own 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 a denial of your medical/family leave request. Your leave is "pending" (awaiting approval) until the Parish/School/Diocese receives the required medical certification.

FOR COMPLETION BY THE HEALTH CARE PROVIDER

Instructions To The Health Care Provider: Your patient has requested leave under the medical/family leave policy of the Parish/School/Diocese. 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. Use the information provided above to answer this question. If you have not been provided a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   Is the employee unable to perform any of his/her job functions due to the medical 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: _____

   _____

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) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

Signature of Health Care Provider **Date**

Printed Name of Health Care Provider