SOUTH GEORGIA MEDICAL CENTER

MEDICAL LOA CERTIFICATION
Non-FMLA (Employee)

Human

Certification of Health Care Provider for Serious Health Condition (Employee)
This Leave of Absence certifies as a Medical LOA for the employee and in order to determine whether leave is covered under the Medical LOA Policy, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient.
SECTION II: For Completion by the EMPLOYEE **INSTRUCTIONS to the EMPLOYEE:** Please complete Section II before giving this form to your medical provider. Your employer expects you to submit a timely, complete, and sufficient medical certification to support a request for Medical leave due to your own serious health condition. If requested by your employer, your response is required to obtain approved leave of absence protection. Failure to provide a complete and sufficient medical certification may result in a denial of your medical leave request. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. The completed form must be returned to Human Resources within 15 calendar days from receipt of this form.

First	Middle	Last	Employee #

SECTION II: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested Medical eave under the Medical Center's Policy. Answer, fully and completely, all applicable parts. 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. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's name and business address:	
Type of practice / Medical specialty:	
Telephone: ( )	Fax: ( )

PART A: MEDICAL FACTS

1. Approximate date condition commenced:

Diagnosis or condition patient treated for:

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 the 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 expect duration of treatment:

2. Is the medical condition pregnancy? ❑ No ❑ Yes. If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide 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 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: <u>AMOUNT OF LEAVE NEEDED</u>

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:

7. CONTINUED

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:_____

Return to Alberta Graham, Human Resources
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