Medical Certification (PART B)

Return to the Benefits Office King, Room 207

All items must be completed. Attach additional pages, if necessary.

Part I: TO BE COMPLETED BY EMPLOYEE (Please Print or Type)	
Employee Name:	Patient's Social Security Number: (Optional) Or Patient's Date of Birth:
Patient's Name: (if patient is not the employee)	Practitioner's Name:
Relationship to Employee: ☐ Self ☐ Spouse ☐ Child ☐ Parent	Practitioner's Area of Practice: (i.e. Internal Medicine)
Practitioner's Phone Number: ____________________ Name of Nurse: ______________________________	Practitioner's Address:

PART II: TO BE COMPLETED BY MEDICAL PRACTITIONER (For patient listed in #3 above)

1. Nature of Serious Health Condition (diagnosis). Please note that this description should not include any genetic information (including genetic tests, the genetic test results of family members, or the manifestation of a disease or disorder in a family member with a genetic cause) unless necessary to comply with the request:

2. Date Condition Commenced (first treated): First Day of Absence form Work:

3. Probable Duration of Condition (calculated from the day you sign this form): ____________________
Is the leave continuous ☐ OR intermittent ☐

4. Regimen of Treatment: (*i.e. your post-operative, post-partum instructions, etc. May attach clinical notes if you prefer)*

Please check "yes" or "no" as appropriate:	Yes	No
5a. Will the patient be hospitalized as either an in-patient or same-day surgery patient?		
5b. Does the patient require assistance for basic medical, or personal needs or safety, or for transportation?		
5c. *If patient is employee,* is the patient able to perform his/her own job functions as described to you?		

5d. Please state why the patient is unable to perform his/her job functions as described in the written job description if the patient is the employee (i.e. list limitations). If for a family member the reason the employee is needed as caregiver:

6. ***If the leave is on an intermittent basis,*** **please indicate the probable duration of this periodic, outpatient treatment:**

______________________________ ____________________

Signature of Practitioner **Date**