Other Medical Leave of Absence

Certification of Health Care Provider for Employees Serious Health Condition

SECTION I: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section I before giving this form to your medical provider. NHRMC's Leave of Absence policy requires that you submit a timely, complete, and sufficient medical certification to support a request for medical leave due to your own serious health condition. Failure to provide a complete and sufficient medical certification may result in a denial of your Other Medical Leave of Absence request. You have 15 calendar days to return this form.

IMPORTANT: In the case of an incomplete, vague or non-responsive medical certification, NHRMC HR Benefits may notify you in writing of the additional information/clarification that is necessary to complete the certification. You then have seven calendar days to provide the requested information. If you fail to submit a complete and sufficient certification despite the opportunity to correct it, we may deny the Other Medical Leave of Absence.

Your name: _____
First Middle Last

Your Job Title: _____ Your regular work schedule: _____

NHRMC Benefit Contacts:

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SECTION II: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested an Other Medical Leave of Absence. 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 Other Medical Leave of Absence 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. **PRINT CLEARLY**

Dr.'s name & Provider's name, Business address: _____

Type of practice/medical specialty: _____

Telephone: (_____)_____ **Fax:**(_____)_____

PART A: MEDICAL FACTS (PRINT CLEARLY FOR TIMELY PROCESSING)

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: Print Clearly.

_____

_____

_____

2. Is the medical condition pregnancy?

_____No _____Yes. If so, expected delivery date: _____

3. Use the information provided in Section I to answer this question. If there is no job description, answer these questions based upon the employee's own description of his/her job functions.

   Is the employee **ABLE** to perform any of his/her job functions due to the condition:

   _____No _____Yes.

   If **NO**, identify the job functions the employee is unable to perform: Print Clearly.

   _____

   _____

   _____

4. **REQUIRED:** Describe relevant medical facts, 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): Print Clearly.

   _____

   _____

   _____

   _____

PART B: AMOUNT OF LEAVE NEEDED

1. 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: _____.

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER. Print Clearly.

_____

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider **Date**