CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE

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SECTION I: INSTRUCTIONS to the EMPLOYEE: Please complete this section before giving this form to your medical provider.

Employee's Full Name: _____ *myWSU* ID # _____

Employee's Job Title: _____ Regular Work Schedule: _____

Employee's Essential Job Functions: _____

Position Description is Attached: ☐ Yes ☐ No

SECTION II: INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave. 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 leave 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: _____

Provider's Address: _____

Type of practice / Medical specialty: _____

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

MEDICAL FACTS

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 yes, 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 yes, state the nature of such treatments and expected duration of treatment:

_____

_____

_____

Is the medical condition pregnancy? ☐ No ☐ Yes If yes, expected delivery date: _____

Use the information provided by the employee in Section I to answer this question. If the employee fails to provide 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 yes, identify the job functions the employee is unable to perform: _____

_____

_____

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):

AMOUNT OF LEAVE NEEDED

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 yes, estimate the beginning and ending dates for the period of incapacity: _____ to _____

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 yes, 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 _____

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 yes, 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 with Your Additional Answer:

_____ _____

Signature of Health Care Provider Date

* "Incapacity," for purposes of medical leave, is defined to mean inability to work, attend school or perform other regular activities due to the serious health condition, treatment therefore, or recovery therefrom.
*Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.
* A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic), or therapy requiring special equipment to resolve or alleviate the health conditions. A regimen of treatment does not include the taking of over-the-counter medications such as Aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

Paperwork Reduction Act Notice and Public Burden Statement

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500.Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT OR TO WICHITA STATE UNIVERSITY HUMAN RESOURCES.**