

FRANKLIN & MARSHALL

Human Resources, CSQ, P.O. Box 3003, Lancaster, PA 17604-3003, Fax: (717) 291-3969

Medical Leave Certification of Physician or Health Care Practitioner

Employee's Full Name: _____

Patient's Name (if other than the employee): _____

Patient's Date of Birth: _____

I authorize the following health-related information to be released to Franklin & Marshall College for the purpose of determining eligibility for Family & Medical Leave and/or other medical leave.

Patient's Signature

Date

To be completed by the patient's health care provider:

1. Does the patient have an illness, injury, impairment, or physical or mental condition that renders the patient unable to work (or incapacitated) for **more than 3 consecutive calendar days** and: requires 2 or more treatments by, or under the supervision of, a health care provider, or requires treatment on at least 1 occasion that results in a regimen of continued treatment? ____ Yes ____ No

2. If yes, please briefly describe the nature of the required treatment (i.e., physical therapy, prescription drug therapy, etc.):

3. Date of 1st medical treatment: _____ Date of 2nd treatment, if applicable: _____

4. Does the patient require inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility? ____ Yes ____ No

5. Does the patient have a permanent or long-term condition for which treatment may not be effective, but which requires on-going supervision by a health care provider, including at least 2 visits/treatments per year? ____ Yes ____ No

6. Is the patient incapacitated due to pregnancy? ____ Yes ____ No or N/A

7. Is the patient unable to work due to elective cosmetic surgery? ____ Yes ____ No

8. Is the patient able to perform modified duty work? ____ Yes ____ No

9. If the patient is able to perform modified duty work, please describe all applicable work restrictions:

(over)

10. If unable to perform any work, on what date was the patient first unable to work? _____

11. Estimated return to work date: _____

12. Does the patient have a chronic health condition which requires periodic treatment by a health care provider (at least 2 visits/treatments per year) and results in *intermittent* periods of incapacity? ____ Yes ____ No

13. If yes, please indicate the probable number of absences from work each month, and probable duration of each absence: _____ estimated # of absences per month _____ # days duration of each absence

14. Is the patient a service member undergoing medical treatment or therapy, or recovering from a "serious injury or illness"; one suffered while on active duty in the Armed Forces that may render the individual medically unfit to perform the duties of the member's office, grade, rank, or rating? ____ Yes ____ No

15. Please describe the medical facts which support your certification provided above:

Additional questions, to be answered by the health care provider, if the employee is applying for Family & Medical Leave to care for a child, spouse, parent, or next of kin with a serious health condition:

1. Does the patient require assistance for basic medical, hygiene, nutritional, safety, or transportation needs? ____ Yes ____ No (If no, skip questions 2 - 4)

2. Is it necessary for the employee to be absent from work to provide care/ assistance to the patient (this may include psychological comfort)? ____ Yes ____ No

3. If yes, please estimate the number of days or weeks it will be necessary for the employee to be absent from work to provide care for the patient: _____ # of days _____ # of weeks

4. If it is necessary for the employee to be absent from work to provide care/ assistance to the patient on an *intermittent* basis, please estimate the number of days per week the employee will be absent from work: _____ # of days per week

Name of Physician or Health Care Practitioner Phone Number

Name and Address of Practice

Signature of Physician or Health Care Practitioner Date

Medical information provided in conjunction with an application for leave will be kept confidential.

Please return this completed form to Human Resources, CSQ, Franklin & Marshall College, P.O. Box 3003, Lancaster, PA 17604-3003, fax: (717) 291-3969.