Medical Certification by Health Care Professional – Employee

Complete this form if leave is due to the employee's own health care condition

Section 1 – To be completed by Employee

Employee Name: Employee ID Number:

What type of time off do you anticipate needing?

❑ A block of time from _____ to _____
Starting Date Ending Date

❑ Intermittent or reduced schedule. Please indicate the probable duration of this need and attach a schedule if applicable:

Authorization to Release Medical Information

I authorize my health care provider to release the protected health information regarding my physical or mental condition (as to how it will affect my work activity), including AIDS/ HIV and other communicable diseases, if applicable, to my employer: Imperial Valley College. By signing this release, I confirm that the information listed above is true and I understand that I am agreeing that my employer can obtain and use such medical information as necessary to process this request for a leave of absence.

Note: This information is retained on a confidential basis consistent with federal and state law.

_____ _____
Employee Signature Date

Section II – To be completed by Health Care Provider – Certification of Employee's Medical Condition

Patient's Name:	First day of Medical Leave:	Probable Duration of Condition:	Anticipated Return to work date:

Check the category that matches the patient's condition. *See attached sheet, which describes what is meant by a "serious health condition"*

☐ 1. Hospital Care	☐2. Outpatient Surgery **Is the surgery:** ☐ Emergent ☐ Non-Emergent	☐ 3. Absence plus Treatment	☐ 4. Chronic Conditions Requiring Treatments
☐ 5. Pregnancy	☐ 6. Permanent/Long-term Conditions Requiring Supervision	☐ 7. Multiple Treatments (Non-Chronic Conditions)	☐ 8. None of the above

Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories.:

If a medical condition requires the employee to be absent from work (including absences due to pregnancy or a chronic condition), <u>is the employee able to perform work of ***any*** kind</u>? **❒ YES ❒ NO**	If able to perform <u>*some work*</u>, is the employee **unable to perform any one or more of the essential functions of the employee's job?** (Employee should provide you with a copy of their job description and physical factors of the job) ❒ YES ❒ NO If <u>*yes*</u>, please indicate the essential function the employee is unable to perform on the ***Medical Release to Work form*** with your signature (attached).

Will it be necessary for the employee to work only intermittently or **to work on a less than full schedule** as a result of the condition (including for treatment)? ❒ **YES** ❒ **NO**

Treatments: Will it be necessary for the employee to be **absent from work for treatment**? **❒ YES ❒ NO**	Will a regimen of continuing treatment for condition be required for the patient? **❒ YES ❒ NO**	Will the **regimen of continuing treatment** by the patient require and be under **your** supervision? **❒ YES ❒ NO**	Will any of the treatments be provided by **another** provider of health services (e.g., physical therapist)? **❒ YES ❒ NO**
	If yes, give the probable number of treatments or probable duration, and the interval between treatments:	If yes, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment, etc.)	If yes, state the nature of the treatment, and provide a general description of such regimen:

Name of Healthcare Provider (Print)	Type of Practice (Specializations, if any)	Telephone Number ( ) -

_____ _____
Health Care Provider Signature Date