**Medical Condition Certification**

**to Receive Leave Donations**

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| **PART I: TO BE COMPLETED BY EMPLOYEE** |
| Employee Name | Personnel Number |
|       |       |
| Agency | Work Location/Building |
|       |       |
| **For absences for family members, state the following:** |
| Patient’s Name (if employee’s family member) | Relationship to Employee |
|       |       |
| **PART II: TO BE COMPLETED BY HEALTH CARE PROVIDER**  |
| **Instructions:** This certification must be fully completed and each question must be answered by the health care provider in order to determine if the employee is eligible for additional leave of absence benefits due to a catastrophic/severe injury or illness. **A Serious Health Condition Certification form must be completed in addition to this form.** |
| **Statement of Medical Condition** |
| **Medical Facts.** Describe the condition and the medical facts which support the patient’s certification of a catastrophic/severe injury or illness. Medical information may also be attached in addition to completion of this section. |
| **Check all that apply and provide the details requested** |
| **Type of Medical Condition**[ ]  This is/was a life threatening injury or illness. Provide date when the injury or illness was no longer life threatening (if applicable):[ ]  This is a chronic, non-life threatening injury or illness with short-term recurrences. [ ]  This is a progressive disease. Provide the current stage of the disease:[ ]  None of the above**Treatment – Check all that apply**[ ]  Patient is/was hospitalized as an inpatient due to this injury or illness. List name of hospital: List all dates of inpatient stay due to the injury or illness:[ ]  Patient is/was in the intensive care unit of the hospital due to this injury or illness. List the dates of intensive care unit:[ ]  Patient was provided emergency treatment due to this injury or illness. List the dates of emergency treatment: Describe the emergency treatment:[ ]  Patient is scheduled for or underwent surgery for this injury or illness. List date(s) of **inpatient** surgery: List date(s) of **outpatient** surgery:[ ]  Patient had complications as a result of surgery and/or the surgery was non-routine.  Explain: |
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| Employee Name:       Personnel Number:        |
| **Medical Condition Severity – Check all that apply** [ ]  Patient, without treatment, would be threatened with a serious residual disability. Explain threat: Explain treatment that alleviates the threat:[ ]  Patient’s condition is verging on a state of crisis or emergency.Explain how:[ ]  Patient’s condition is severely affecting quality of life. Explain how:[ ]  Patient requires a strict regimen of treatment to maintain quality of life. Explain regimen:[ ]  Patient’s condition requires a high level of constant care to maintain comfort or sustain life.  Explain care and who provides care:[ ]  Patient’s condition requires attention to a bodily function that cannot be managed without intervention. Explain:[ ]  Patient’s condition is permanent.**Type of Incapacity**[ ]  Full-time absence.[ ]  Intermittent absence for treatment only and recovery from treatment.[ ]  Intermittent absence for treatment, recovery from treatment and flare-ups of the injury or illness. |
| **By providing my original signature, the undersigned health care provider certifies that the information is true and accurate.** |
| Printed Name of Health Care Provider | Type of Practice | License Number |
|  |  |  |
| Address | Telephone Number |
|  |  |
| Name and Title of Person Completing the form, if not the Health Care Provider |
|  |
| Signature of Health Care Provider | Date |
|  |  |

**Return completed form to the employee or return it directly by mail or fax to:**

**[Name]**

**[Title]**

**[Name of Employer]**

**[Address]**

**[Phone]**

**[Fax]**