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| **PART I: TO BE COMPLETED BY EMPLOYEE** |
| Employee Name | Personnel Number |
|       |       |
| Agency | Work Location/Building |
| CORRECTIONS |       |
| **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 to determine the employee’s eligibility for additional paid absence benefits that may be used intermittently for absence periods of less than six consecutive work days. **A Serious Health Condition Certification form must be completed in addition to this form, if one was not already completed.** |
| **Statement of Medical Condition** |
| **Medical Facts.** Describe the condition and the medical facts which support the patient’s medical condition and need for short-term absences. Additional medical information may also be attached.Approximate date of diagnosis? |
| **Medical Condition Information** (check all boxes that apply and provide details) |
| [ ]  This condition is of long duration and has slowly progressed to its current state.[ ]  This condition has continual symptoms.[ ]  This condition has intermittent symptoms.[ ]  This condition is permanent.[ ]  This condition is not permanent, and is anticipated to be completely resolved with treatment. Estimated date of resolution:**Comments:** |
| **Treatment Information** (check all boxes that apply and provide details) |
| [ ]  Patient’s chronic short or long term illness or disability requires a regimen of treatment administered by a licensed health care provider. [ ]  Regimen of treatment is performed by a health care provider. [ ]  Regimen of treatment is self-administered by the patient as directed by the health care provider.Explain regimen, and if regimen is self-administered by the patient, what supervision, if any, is provided by the health care provider?[ ]  Patient’s illness or disability does not require a regimen of treatment. **Comments:** |

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| **Type of Leave Needed** (check all boxes that apply and provide details)Please review this employee’s work schedule (attached) prior to answering the following questions. |
| [ ]  Full-time absence.  List begin and end date of full-time absence needed:[ ]  Intermittent absence for appointments.  [ ]  During appointments, treatment is being provided. [ ]  During appointments, no treatment is provided; appointments are for evaluation of the condition. Define estimated frequency and estimated amount of time required for each appointment:[ ]  Intermittent absence for treatment. Define schedule, frequency and estimated amount of time needed for each treatment: Define estimated amount of recovery time needed for each treatment:[ ]  Intermittent absence for flare-ups of the injury or illness only, with no regimented treatment.[ ]  Absence is not medically required due to this condition, nor is it required for recovery or flare-ups. Appointments/treatments can be scheduled during non-work hours (refer to work schedule). **Comments:** |
| **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:**

**SPF Absence Section**

**PA Department of Corrections**

**1920 Technology Parkway**

**Mechanicsburg, PA 17050**

**Phone: 717.728.5341**

**Fax: 717.728.0338**

**Email: ra-censpf@pa.gov**