CERTIFICATION OF PHYSICIAN OR HEALTH CARE PROVIDER FOR ILL EMPLOYEE

HUMAN RESOURCES
200 N. Bernard St.
Spokane, WA 99201-0282
Phone: (509) 354-7265
Fax: (509) 354-5963

Spokane Public Schools
excellence for everyone

EMPLOYEE'S NAME: _____ ID#_____

Your patient has requested leave from their current position. Please answer fully and completely. Be as specific as you can; terms such as **"lifetime," "unknown," or "indeterminate"** are not sufficient to determine leave coverage. Limit your responses to the condition for which the employee is seeking leave.

FIRST DAY OFF WORK OR IN REDUCED SCHEDULE:	RETURN DATE or PROBABLE DURATION OF CONDITION:	❑ Actual ❑ Estimated

Date condition commenced (if different than date listed above): _____

Diagnosis: _____

_____

Dates you treated the patient for condition: _____

Schedule of visits or treatments and/or anticipated review date: _____

_____

❑ YES ❑ NO ❑ N/A Is inpatient care in a hospital, hospice or residential medical-care facility required?

❑ YES ❑ NO ❑ N/A Is the employee able to perform the functions of his/her position? (Answer after reviewing statement from employer of essential functions of employee's position or, if none provided, after discussing with employee.)
If the answer is no please identify the job functions the employee is unable to perform:

_____

❑ YES ❑ NO ❑ N/A If answer to above question is no, are there any other district positions which the employee may be able to perform? Please explain below:

_____

❑ YES ❑ NO ❑ N/A Does the employee suffer from a serious, severe or life threatening condition? (This question is for determining shared leave eligibility).

❑ YES ❑ NO ❑ N/A Will the patient need to have treatment visits a least twice per year due to the condition?

❑ YES ❑ NO ❑ N/A Was medication, other than over-the-counter medication, prescribed?

❑ YES ❑ NO ❑ N/A Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
If so, state the nature of such treatments and expected duration of treatment:

_____

❑ YES ❑ NO ❑ N/A Is the condition pregnancy?
If so, expected delivery date:_____

Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave:

_____

_____

❑ YES ❑ NO ❑ N/A 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?
If so, estimate the beginning and ending dates for the period of incapacity:

_____

❑ YES ❑ NO ❑ N/A 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?

❑ YES ❑ NO ❑ N/A If so, are the treatments or the reduced number of hours of work medically necessary? 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_____

❑ YES ❑ NO ❑ N/A Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions?

❑ YES ❑ NO ❑ N/A Is it medically necessary for the employee to be absent from work during the flare-ups? If so, explain:

_____

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and duration and 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

NOTES: _____

_____

_____

EMPLOYEE SIGNATURE: _____ DATE: _____

HEALTH CARE PROVIDER'S NAME: _____PHONE: _____

TYPE OF PRACTICE / MEDICAL SPECIALTY: _____FAX:_____

HEALTH CARE PROVIDERS SIGNATURE: _____ DATE: _____

- RETURN TO HUMAN RESOURCES -