CERTIFICATION OF HEALTH CARE PROVIDER – SHARED LEAVE PROGRAM FOR EMPLOYEE'S SERIOUS HEALTH CONDITION

NOTE: IF APPLYING FOR FMLA OR MEDICAL LEAVE, ADDITIONAL FORMS ARE REQUIRED

SECTION I: FOR COMPLETION BY EMPLOYEE

Please complete Section I before giving this form to your medical provider.

Your Name (Printed): _____

First *Middle* *Last*

Name of family member for whom you will provide care: _____

Relationship of family member to you: _____

If Child, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

SECTION II: FOR COMPLETION BY LICENSED HEALTH CARE PROVIDER

Your patient has requested leave for a catastrophic event. **Please note that we are defining a catastrophic event as "a major illness, injury or medical condition which is life threatening, terminal or likely to result in a substantial permanent disability as certified in writing by a health provider"**. Based on the definition of catastrophic event, answer, fully and completely, all applicable parts. Your answers should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's Name and Business Address: _____

Type of Practice / Medical Specialty: _____

Office Telephone: _____

Office Fax: _____

PART A │MEDICAL FACTS

Is the patient identified above experiencing a major illness, injury, or medical condition that meets one of the following descriptions:

1. Is this a life threatening condition? ☐Yes ☐No _____Licensed Provider Initials
2. Is this a terminal condition? ☐Yes ☐No _____Licensed Provider Initials
3. Is this likely to result in a permanent disability? ☐Yes ☐No _____Licensed Provider Initials

PART B │AMOUNT OF LEAVE NEEDED

If you answered yes to one of the items in Part A, please provide your estimate of the period for which the major illness, injury, or medical condition will require the employee's absence from work. :

Begin:	**End:**

By signing below, I certify that I, and no one else, has completed this certification and all information provided is true and correct to the best of my knowledge.

Signature of Health Care Provider Date:

Printed Name of Health Care Provider and Degree Level (MD, DO, FNP, etc.)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you do not provide any genetic information when responding to this request for medical information. "Genetic Information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproduction