Employee and Retiree Service Center
MONTGOMERY COUNTY PUBLIC SCHOOLS
Rockville, Maryland 20855

CERTIFICATION OF PHYSICIAN OR HEALTH CARE PROVIDER

PART I: PATIENT INFORMATION—To be completed by employee.

Employee _____ Employee No. 0000 _____ Date ____/____/____
Last *First* *MI*

PART II: FOR CERTIFICATION RELATING TO THE EMPLOYEE'S OWN SERIOUS HEALTH CONDITION—To be completed by the physician or health care provider to verify services.

Estimated dates of absence: From ____/____/____ Thru ____/____/____
(Beginning and end dates must be specified and must coincide with days of leave of absence. If an end date can not be specified, please state this and enter date of next appointment.)

Regimen of Treatment to be Prescribed: (Indicate number of visits, general nature and duration of treatment, including referral to other provider of health services. Include schedule of visits or treatment if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week.)

INFORMATION RELATING TO THE EMPLOYEE'S OWN SERIOUS HEALTH CONDITIONS.

Date condition commenced: ____/____/____

State diagnosis and regimen of treatment to be prescribed: _____

_____

_____

_____

	Yes	No	
1.	☐	☐	Is inpatient hospitalization of the employee required?
2.	☐	☐	Is the employee able to perform work of any kind? (If "No," Skip item 3.)
3.	☐	☐	Is the employee able to perform the functions of the employee's position? (Answer after reviewing statement from employer of essential functions of employee's position, or, if none provided, after discussing with employee.)

If absence is related to pregnancy, give estimated delivery date: ____/____/____

PART III: FOR CERTIFICATION RELATING TO CARE FOR THE EMPLOYEE'S SERIOUSLY ILL FAMILY MEMBER—To be completed by physician or health care provider to verify services.

Employee's family member: _____ Relationship to employee: _____
Last *First*

Employee's estimated dates of absence: From ____/____/____ Thru ____/____/____

	Yes	No	
4.	☐	☐	Is inpatient hospitalization of the family member (patient) required?
5.	☐	☐	Does (or will) the patient require assistance for basic medical, hygiene, or nutritional needs, or for safety or transportation?
6.	☐	☐	Is the employee's presence necessary or would it be beneficial for the care of the patient? (This may include psychological comfort.) **If "Yes"**:

Describe care needed: _____

_____

_____

Estimate the period of time care is needed or the employee's presence would be beneficial including a schedule if leave is to be taken intermittently or on a reduced-leave schedule.

_____

_____

_____

PART IV: AUTHORIZATION—To be completed by physician or health care provider to verify services.

_____ _____
Print Name of Physician or Health Care Provider *Phone Number*

_____ ____/____/____ _____
Signature, Physician or Health Care Provider *Date* *Type of Practice/Field of Specialization*

If question is required concerning this case: _____ _____
Print Name of Contact Person *Phone Number*

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