MEDICAL CERTIFICATION
FOR EMPLOYEE'S OWN SERIOUS HEALTH CONDITION/MATERNITY

Please return completed forms to Absence Management
14201 School Lane, Room 132. Upper Marlboro, MD 20772.
Phone: 301-952-6200. Fax: 301-760-3593. Email:absence.mgmt@pgcps.org

SECTION I: TO BE COMPLETED BY THE SUPERVISOR (REQUIRED):
I have been informed of named employee's request for an extended leave beyond (10 consecutive duty days).
Note: *I understand my signature is merely an acknowledgement of an employee requesting an extended leave and not an approval. My delay or failure to sign this request may place the employee in an unpaid leave status. Absence Management makes all decisions regarding extended leaves (i.e. FMLA/LOA/SLB).*

Supervisor Signature: _____ **Date:** _____

SECTIONI II: TO BE COMPLETED BY THE EMPLOYEE: Please complete Section II before giving this form to your health care provider.

Employee's Name: _____ EIN: _____
First Middle Last

Work Organization: _____ Job Title: _____

Is this health condition related to work injury? ☐ **Y**es ☐ **N**o Worker's Compensation Claims #_____

Have you filed a Worker's Compensation for this illness/injury? ☐ **Y**es ☐ **N**o Date of Injury: _____

Have you will/apply to the SLB? ☐ **Y**es ☐ **N**o *****Do you elect to use your projected leave? ☐ **Y**es ☐ **N**o

*****Do you elect to use all earned leave time, including personal leave to cover any portion of leave without pay? ☐ **Y**es ☐ **N**o

***** If maternity, number of weeks requested _____ **(12 weeks Maximum)**

***Once selected, you cannot change your election. Please review carefully before selecting you option.**

To qualify for an extended leave or FMLA entitlements, you must submit a complete, sufficient, and timely medical certification to support a request for FMLA leave due to your own serious health condition. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification will result in a denial of your leave request. You will have 15 calendar days to return this form to Absence Management.

By signing below, I authorize all treating provider(s) to release information obtained in the course my evaluation and treatment to Absence Management. Further, I grant Absence Management permission to verify all supporting documents to determine eligibility and FMLA entitlements. Absence Management can share my medical information with any health care provider consulted for further medical opinion on my behalf.

I must submit an Request for Extension Form or Certificate of Medical Release Form to Absence Management 10 days prior to approved leave ending. An employee cannot return to work without a medical release.

Employee's Signature:_____**Cell Phone #:** _____ **Date:**_____

SECTION III: FOR HEALTH CARE PROVIDER ONLY: Your patient has requested an extended leave or a leave under the FMLA for a **serious health condition**. Where indicated, your documentation should provide specific dates. Terms such as, "lifetime," "unknown," or "unable to determine" will not be sufficient to determine eligibility for an extended leave. If medical decision requires documentation of uncertain frequency and uncertain duration of a condition, your best estimation of time and frequency is required. If needed, utilize the last page for further documentation.

PGCPS

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PART A: REQUIRED DOCUMENTATION OF SERIOUS HEALTH CONDITION BY THE HEALTH CARE PROVIDER

Please limit your responses to the serious health condition for which the employee seeks a leave

Diagnosis & ICD Code(s)	Prognosis	Severity of the Health Condition	Impact on Essential Job Function

Approximate start date of the serious health condition: _____

What is the usual recovery period for this condition? _____

If overnight stay in a hospital, hospice, or residential medical care facility: Date:_____

Surgery/Procedure:_____ Date: _____

Specify treatment plan: medication, therapies, etc. _____

Specify newly prescribed or adjusted medication for this health condition (other than over the counter medication):

_____

Was the patient referred for further evaluation/ treatment? ☐ Yes ☐ No.

If yes, state the nature of such treatments and expected duration of treatment:_____

Referral made to: Physician/Doctor's Name: _____Specialty:_____

Physician/Doctor's phone number_____

2. Is this a pregnancy? ☐ Yes ☐ No. If so, expected delivery date: _____

PART B: AMOUNT OF LEAVE NEEDED: CHOOSE ONLY ONE OPTION BELOW:

☐ **Will the employee's absence be for a continuous period, including any time for treatment and recovery?**

Beginning date: _____/_____/_____ **Ending date**: _____/_____/_____
Month Day Year Month Day Year

OR

☐ **Will the employee still continue to work will receiving treatment /recovery (intermittent leave)?**

Beginning date: _____/_____/_____ **Ending date**: _____/_____/_____
Month Day Year Month Day Year

Frequency of treatment/recovery: #of hours per day_____ or # of days per month _____

ADDITIONALLY: Will the condition cause flare-ups requiring additional periods of absence? ☐ **Y**es ☐ **N**o.

If yes, estimate the frequency of flare-ups and the duration of absence, that employee may have over the next 6 months

Frequency and duration: # of hours per day: _____# of days per week: _____, **or** # of days per month: _____

SPACE FOR ADDITIONAL INFORMATION (IF NEEDED):

_____

_____

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

Health Care Provider's Name: _____Provider's ID#_____(Required)

Type of Specialty: _____

Business Address: _____ Telephone: _____

Signature of Health Care Provider: _____Date:_____