The Texas A&M University System

Sick Leave Pool/Direct Donation Medical Certification Form
for Employee’s Serious Health Condition

With few exceptions, you have the right to request, receive, review and correct information about yourself collected using this form.

For Completion by the HEALTH CARE PROVIDER:

Answer fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer 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. Sign the form on Page 2.

__________________________________________________________________________________

Employee name

__________________________________________________________________________________

Date incapacity commenced                   Date treatment first received

Health Care Provider printed name:________________________________________________________

Health Care Provider business address: __________________________________________________

Telephone: (____)__________________________

Type of practice/medical specialty: _______________________________________________________ 

PART A: MEDICAL FACTS

1. Approximate date condition commenced: ________________________________________________

   Probable duration of condition: ________________________________________________________

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ___ No ___ Yes. If so, dates of admission: _______________________________________________

   Date(s) you treated the patient for condition: _____________________________________________

   Will the patient need to have treatment visits at least twice per year due to the condition? ___No ___ Yes.

   Was medication, other than over-the-counter medication, prescribed? ___No ___ Yes.

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   ___ No ___ Yes. If so, state the nature of such treatments and expected duration of treatment:
   ________________________________________________________________________________

2. Is the medical condition pregnancy? ___No ___ Yes. If so, expected delivery date:  _______________________

3. Is the employee unable to perform any of his/her job functions due to the condition? (the employee or employer can provide a list of essential functions)
   ___ No ___ Yes. If so, identify the job functions the employee is unable to perform:
   ________________________________________________________________________________
   ________________________________________________________________________________
   ________________________________________________________________________________
4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

PART B: AMOUNT OF LEAVE NEEDED
5. 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?  No  Yes.

If so, estimate the beginning and ending dates for the period of incapacity: _____________________________________________________________

6. 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?  No  Yes.

If so, are the treatments or the reduced number of hours of work medically necessary?  No  Yes.

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 _________

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions?  No  Yes.

Is it medically necessary for the employee to be absent from work during the flare-ups?  No  Yes.

If so, explain:

________________________________________________________________________

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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

________________________________________________________________________
________________________________________________________________________

________________________________________  ___________
Health Care Provider signature  Date