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***