

# Sick Leave Pool Medical Certification Form for Employee's Family Member'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 EMPLOYEE

\_\_\_\_\_  
*Employee name*

\_\_\_\_\_  
*Family member name/relationship*

If family member is your son or daughter, date of birth: \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
*Employee signature*

\_\_\_\_\_  
*Date*

## 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 family member's condition for which the employee is seeking leave. Sign the form on Page 3.

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. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**PART B: AMOUNT OF CARE NEEDED**

When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery?  
\_\_\_ No \_\_\_ Yes.

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

During this time, will the patient need care? \_\_\_ No \_\_\_ Yes.

If so, explain the care needed by the patient and why such care is medically necessary:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

5. Will the patient require follow-up treatments, including any time for recovery? \_\_\_ 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:

\_\_\_\_\_

\_\_\_\_\_

Explain the care needed by the patient and why such care is medically necessary: \_\_\_\_\_

\_\_\_\_\_

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?

\_\_\_ No \_\_\_ Yes.

Estimate the hours the patient needs care on an intermittent basis, if any:

\_\_\_\_\_ hour(s) per day; \_\_\_\_\_ days per week from \_\_\_\_\_ through \_\_\_\_\_

Explain the care needed by the patient and why such care is medically necessary: \_\_\_\_\_

\_\_\_\_\_

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? \_\_\_ No \_\_\_ Yes.

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

Does the patient need care during these flare-ups?

If so, explain the care needed by the patient and why such care is medically necessary:

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**ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.**

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\_\_\_\_\_  
*Health Care Provider signature*

\_\_\_\_\_  
*Date*