COUNTY BOARD OF HEALTH

CERTIFICATION OF SERIOUS HEALTH CONDITION

FORM TO BE COMPLETED BY HEALTH CARE PROVIDER:

Employee's Name:	Patient's Name and Relationship to Employee (if different from employee):

Please check the applicable category.

	Hospital Care
	Absence plus Treatment
	Pregnancy
	Chronic Conditions Requiring Treatments
	Permanent / Long-term Conditions Requiring Supervision
	Multiple Treatments (Non-Chronic Conditions)
	None of the above

SECTION 1: ***Complete this section for the serious health condition of the employee.***

Describe the medical facts that support the employee's need to be absent from work due to a serious health condition.

Approximate date condition began:	**Expected duration of condition:**

Describe the regimen of treatment prescribed (including number of visits, general nature and duration of treatment, referral to other health service providers, etc.)

Is inpatient hospitalization required? ❑ Yes ❑ No

Is the employee able to perform work of any kind? ❑ Yes ❑ No

Is the employee able to perform essential job functions, with or without reasonable accommodation? ❑ Yes ❑ No
If yes, please describe recommended accommodation, if any:

If the employee is able to perform some or all essential job functions, will it be necessary for the employee to be absent from work on an intermittent basis (e.g., to attend weekly therapy appointments) or to work less than a full work week (e.g., to work 20 hours per week rather than 40 hours?)
❑ Yes ❑ No *If yes, please describe:*

SECTION 2: ***Complete this section for*** **CERTIFICATION OF PREGNANCY/CHILD BIRTH**
This section is to document family and medical leave for pregnancy, child birth and care of a newborn child.

ATTENDING HEALTH CARE PROVIDER:
PLEASE COMPLETE THIS SECTION FOR FEMALE EMPLOYEES ONLY

This is to certify that the employee named above is expected to become, or became, a biological parent on:		DATE:
It is anticipated that the employee will be unable to work	FROM (date):	TO(date):
Barring unforeseen complications, she should be able to return to work on		DATE:
If the period during which the employee is unable to work exceeds two weeks prior to delivery or six weeks after delivery, please provide the medical facts that support the additional period of serious health condition:		

ATTENDING HEALTH CARE PROVIDER:
PLEASE COMPLETE THIS SECTION FOR MALE EMPLOYEES ONLY

This is to certify that the employee named above is expected to become, or became, a biological parent on	DATE:	
The employee's presence is needed due to the pregnancy, child birth and/or care for the mother and/or newborn child from	FROM (date):	TO (date):
Additional comments/explanation:		

NOTE TO EMPLOYEES: *Any period of incapacity due to pregnancy or continuing treatment for prenatal care is considered a serious health condition for purposes of family and medical leave. Sick leave may be used only for reasons that qualify for sick leave as described in CBOH Policy #HR-03422 - ANNUAL, SICK AND PERSONAL LEAVE POLICY.*

SECTION 3: ***Complete this section for the serious health condition of an employee's family member.***

Please indicate the dates for which the employee's presence is necessary to care for a family member with a serious health condition:

FROM (date):	TO (date):

Describe the **medical facts** that support the employee's need to be absent from work to care for a family member with a serious health condition, including care for basic medical or personal needs and/or psychological comfort.

Will it be necessary for the employee to be off work on an intermittent basis or to work less than the normal work schedule to care for the family member? ❑ Yes ❑ No *If yes, please describe:*

SECTION 4: ***Attending Health Care PROVIDER complete this section.***	
Additional Comments:	
Signature of Health Care Provider	**Date:**
Address:	
Phone Number:	**Type of Practice**