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

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

PGCPS

SECTIONI I: TO BE COMPLETED BY THE EMPLOYEE:

Please complete Section I 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? ___**Yes** ___ **No** Worker's Compensation Claims #____________

*Do you elect to use your projected leave? ____ **Yes** ____ **No** (**Subject for review and approval).**

*Do you elect to use: Personal/Annual leave ____**Yes**____**No**; Sick leave ____**Yes**____**No** to cover your FMLA/LOA leave? **(You must make a selection. If no selection is made you will automatically be charged earned sick leave)**

*If maternity, number of days requested __________ (**60 days Maximum)**

If paternity, number of days requested __________ **(60 days Maximum) Start Date:_________ End Date:__________
Documentation to confirm family relationship required.

*** **Please remember to add your newborn to your benefits through Oracle Self-Service within 35 days of birth. If you need assistance contact Benefits Services at 301-952-6600.** ***

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

Employee's Signature:_____________________Cell Phone #: ________________ Date:____________

Due to HIPPA LAW: This form should be kept confidential and provided to Absence Management ONLY upon completion

SECTION II: FOR HEALTH CARE PROVIDER ONLY: Your patient has requested an extended leave or a leave under 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.

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

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: ________

Is this a pregnancy? _________________________Yes ____No. If so, expected delivery date: _________________________

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

****All requests are required to have an estimated ending date in order to determine eligibility. This will not be used as an official release date.** ***A Certificate of Medical Release is required ten (10) prior to the employee's return.*****

☐ **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** (**estimated ending date)**

OR

☐ **Will the employee still continue to work will receiving treatment /recovery (intermittent leave)?** Frequency of treatment/recovery:
\# of days per month ______ (**8 days max).**

Beginning date: ______/_______/_______ **Ending date**: _____/______/_____
Month Day Year **Month Day Year** **(estimated ending date)**

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:**_______________________

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