Sick Leave Pool Medical Certification Form

Employee Name: _____ **Patient Name:** _____

To be completed by licensed practitioner

Please answer, fully and completely. Answers should be your best estimate based upon your knowledge, experience and examination of the patient.

1. Describe relevant medical facts, related to the patient's condition (symptoms, diagnosis, etc).
_____
_____
_____
_____
_____
_____
_____

2. Is the patient's condition a catastrophic illness or injury, which is defined as:
   A **severe** condition or combination of conditions affecting the mental or physical health of the employee or the employee's immediate family that requires the services of a licensed practitioner for a **prolonged period** of time. A prolonged period of time is generally considered at least 45 calendar days. (Note: For purposes of this policy, pregnancy and non-medically necessary cosmetic surgeries not considered severe conditions, except when life-threatening complications arise from them.)
   Yes _____ No _____

3. Approximate date condition(s) commenced and date(s) you treated patient:
_____

4. What is the expected duration the severe condition or combination of conditions will prevent our employee from working? _____ Days _____ months

_____

Licensed Practitioner Signature: _____

Printed Name: _____ Date: _____ Phone: _____

Type of Practice: _____ Fax: _____