Murray
MURRAY STATE UNIVERSITY™
Human Resources

HEALTH CARE PROVIDER'S CERTIFICATION

Return to: Murray State University, 412 Sparks Hall, Murray, KY 42071

Employee's Name: _____ **Birth Date:** _____

Address: _____

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested medical leave from his or her position at Murray State University. Please 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. Be as specific as you can; terms such as "lifetime", "unknown", or "indeterminate" may not be sufficient to determine leave coverage. Limit your responses to the condition for which the employee is seeking leave. **Thank you.**

Provider's name and business address:

_____

_____

Type of practice/Medical specialty: _____

Telephone: (_____) _____ Fax: (_____) _____

PART A: MEDICAL FACTS

1. Diagnosis: _____

2. Approximate date condition commenced: _____

3. Probable duration of condition: _____

4. Anticipated return to work date: _____

5. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

   □ No □ Yes If so, dates of admission: _____

6. Did patient have surgery: □ No □ Yes If so, list type of surgery and date: _____

7. Date(s) you treated the patient for condition: _____

8. Date of next scheduled office visit: _____

9. Will the patient need to have treatment visits at least twice per year due to the condition? □ No □ Yes

10. Was medication, other than over-the counter medication, prescribed? □ No □ Yes

11. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

   □ No □ Yes If so, please state the nature of such treatments and expected duration of treatment:

   _____

12. Is the employee unable to perform any of his/her job functions due to the condition (See enclosed Job Specifications Sheet please):

   □ No □ Yes If so, identify the job functions the employee is unable to perform:

   _____

13. 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. Include a brief statement as to how these facts meet the criteria of a catastrophic illness or injury:

_____

_____

_____

_____

14. 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:

_____

15. 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 reduced number of hours of work medically necessary? □ No □ Yes

16. 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 _____ hours(s) per day:

_____ days per week from _____ through _____.

17. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions?
□ No □ Yes If yes, please answer A and B below.

A. Is it medically necessary for the employee to be absent from work during the flare-ups? □ No □ Yes

If so, please explain: _____

B. 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

18. Any additional information: (Please identify question number with your additional answer)

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider Date