SISTERS OF PROVIDENCE
HEALTH SYSTEM

Human Resources
Mercy Medical Center Campus
271 Carew Street • P. O. Box 9012
Springfield, MA 01102-9012
413-748-9620

CERTIFICATION OF PHYSICIAN OR PRACTITIONER
(Non-FMLA Medical Leave of Absence)

I agree to provide a medical certificate from a physician verifying the serious health condition of myself, my spouse, child, or parent. I hereby authorize SPHS Occupational Health Services to contact my physician to verify the reason for my requested leave or for any other related information concerning my leave.

Employee Signature _____ Date _____

1. Employee's Name: _____ SPHS Facility: _____

2. Patient's name (If other than employee): _____

3. Check the applicable category - **Serious Health Condition** – Diagnosis (Check one)

   1) ___ Hospital Care
   2) ___ Pregnancy/Prenatal Care
   3) ___ Permanent/Long-term condition requiring supervision
   4) ___ Multiple Treatments (Non-Chronic) conditions including recovery
   5) ___ Chronic Condition requiring treatments
   6) ___ Absence plus Treatment (two or more times) by a health care provider at least one occasion with continuing treatment under supervision of health care provider

4. Describe the **medical facts** which support your certification (Diagnosis):_____

   _____

   _____

5. a. State the approximate **date** the condition commenced:_____

   b. Will it be necessary for the employee to take work **intermittently**? If yes, give probable **duration**:_____

   _____

   c. If condition is **chronic** or **pregnancy** state whether patient is presently incapacitated and the likely duration:

   _____

Non-FMLA Medical Leave – Employee's Own Serious Illness

1. a. If additional **treatments** will be required for the condition, provide an estimate of the probable number of such treatments: _____

   b. If the patient will be absent from work or other daily activities because of **treatment** on an **intermittent** or **part-time** basis, also provide an estimate of the probably number of and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:_____

   _____

   _____

   c. If any of these treatments will be provided **by another provider of health services** (e.g. physical therapist), please state the nature of the treatments: _____

   _____

   _____

d. **If a regimen of continuing treatment** by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment): _____

_____

_____

2. a. If medical leave is required for the employee's **absence from work** because of the **employee's own condition** (including absences due to pregnancy or a chronic condition), is the employee **unable to perform work** of any kind? explain: _____

_____

_____

b. If able to perform some work, is the employee **unable to perform any one or more of the essential functions of the employee's job** (the employee or the employer should supply you with information about the essential job functions)? If yes, please list the essential functions of the employee is unable to perform:_____

_____

_____

c. If neither a nor b applies, is it necessary for the employee to be **absent from work for treatment**? Explain: _____

_____

_____

Non-FMLA Medical Leave – To Care for Seriously ILL Family Member:

1. a. If leave is required to **care for a family member** of the employee with a serious health condition, **does the patient require assistance** for basic medical or personal needs or safety or for transportation? Explain: _____

_____

_____

b. If no, would the employee's presence to provide **psychological comfort** be beneficial to the patient or assist in the patient's recovery? Explain: _____

_____

_____

c. If the patient will need care only **intermittently** or on a part-time basis, please indicate the probable **duration** of this need: _____

_____

_____

2. State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule: _____

_____

_____

_____

_____ _____

Signature of Physician or Practitioner Type of Practice:

_____ _____

Address Telephone Number

_____ _____

Date