CERTIFICATION OF HEALTH CARE PROVIDER FOR SERIOUS HEALTH CONDITION

Shared Leave_____ Maternity/Paternity Leave _____ Leave of Absence _____

PURPOSE of FORM: The below-named employee has requested a leave of absence for his/her health condition or a family members' serious health condition. This medical certification form will provide the Human Resources Department with information needed to determine if the employee's requested leave is for a qualifying reason. Section III must be fully completed by the health care provider. If an employee is eligible for Family Medical Leave, the FMLA certification may be required. Refer to the FMLA policy for specific guidelines.

INSTRUCTIONS to EMPLOYEE: You are required to submit a timely, complete, and sufficient medical certification to support your leave due to your own serious health condition. Providing this completed form is required to obtain (or retain) the leave approval. Failure to provide a complete and sufficient medical certification to the Forsyth County Human Resources Department may result in a delay or denial of your leave request.

This form should be completed and returned within 15 calendar days of our request for this information.

The 15 calendar day deadline is _____.

You may return the form in person, by mail, or by fax. The fax number is _____

You may fax this form without a cover sheet: ATTENTION:_____

SECTION I: To be completed by HUMAN RESOURCES

HUMAN RESOURCES CONTACT	HUMAN RESOURCES ADDRESS
PHONE NUMBER	

SECTION II: To be completed by EMPLOYEE

EMPLOYEE'S NAME	EMPLOYEE'S JOB TITLE	WORK SCHEULE
ADDRESS	PHONE NUMBER	DEPARTMENT

_____ Check if a job description listing essential functions is attached.

SECTION III – To be completed by HEALTHCARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient (our employee) has requested a medically related leave of absence. 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 employee. Be specific as you can; terms such as "indefinite,""unknown," or "indeterminate" may not be sufficient to determine eligibility. **Limit your responses to the condition for which the employee is seeking leave**. Be sure to sign and date the form on page 2.

THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA): The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

NOTE: DO NOT DISCLOSE THE EMPLOYEE'S UNDERLYING DIAGNOSIS WITHOUT HIS/HER CONSENT.

PROVIDER'S NAME

ADDRESS

TELEPHONE | FAX

PART A: MEDICAL FACTS

(1) Approximate date condition commenced: _____

Probable duration of condition:
From: _____ To: _____

(2) Page 3 describes what is meant by a "serious health condition."
Does the employee's condition qualify as one of the types of serious health conditions described? Yes No

If yes, which type of serious health condition listed on Page 3 applies:

1 2 3 4 5 6 7

(2 a.) Describe the medical facts that would support the need for this leave. If this medical condition is catastrophic as defined on page 3, describe how it meets the definition of catastrophic.

(3) Use the job description provided by the County in Section II to answer these questions.

Is the employee able to perform work of any kind?	Yes	No
If "Yes," is the employee unable to perform one or more of the essential functions of his/her position? Answer "Yes" if intermittent or reduced schedule leave is medically necessary.)	Yes	No

PART B: AMOUNT OF LEAVE NEEDED

(4) 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? Yes No

If yes, estimate the beginning and ending dates for the period of incapacity: FROM _____ TO _____

PART C: MEDICAL FACTS (REQUEST FOR FAMILY MEMBER ONLY)

(5) If the leave is required to care for a family member with a serious health condition, does the family member require assistance for basic medical, personal, safety or transportation needs?

Part D: SIGNATURE

SIGNATURE OF HEALTH CARE PROVIDER | DATE