Certification Heath Care Provider **Your logo**

Non FMLA Leave **and school/parish name**

Instructions

This form is intended for use to substantiate the need for use of sick leave or long-term leave due to medical conditions. Do not use this form if requesting leave under the Family Medical Leave Act - FMLA.

If you are (1) applying for a long-term leave of absence that involves your own medical condition, or (2) have been asked to provide information to your supervisor to substantiate use of sick leave, please follow these steps:

1. Take this form to the health care provider who is treating you along with the copy of your job description provided by HR.
2. Ask the health care provider to complete this form and return it to you or to send it to (appropriate person at your location). They can fax it to XXX-XXX-XXXX or scan and e-mail it to

Patient's Name: _____

1. State the approximate date the condition commenced and the probable duration of the condition.

2. If the condition is a chronic condition, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity.

3. Is a continuing treatment plan required? If so, provide a general description of the frequency and duration.

4. Medical Leave
   a. If medical leave is required for the employee's absence from work (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind?

   b. If able to perform some work, is the employee unable to perform any one or more of the essential job functions as identified in the attached job description? If yes, please list the essential functions the employee is unable to perform.

_____ _____

Signature of Heath Care Provider Type of Practice

_____ _____

Street Address Telephone Number

_____ _____

City State Zip Date