Please return form to: EWU Benefits Office
Fax: 509-359-2874 Benefits
Office Location: 318 Showalter Hall Cheney, WA 99004
Questions? Call 509-359-4300

HEALTH CARE PROVIDER MEDICAL CERTIFICATION

A	EMPLOYEE COMPLETES SECTION A

A complete medical certification is required to determine whether your health condition or the health condition of your family member qualifies for a medical leave of absence.

Complete the EMPLOYEE/PATIENT information in Section A and the Employee Name field on top of the next page. The Health Care Provider (HCP) must fully complete Section B and certify the information at Section C. It is your responsibility to ensure the completed form is returned to Benefits Office to process your request.

EMPLOYEE/PATIENT INFORMATION (please Print)

Name of Employee (Last, First, MI)	(If applicable) Patient's relationship to employee: ______________________
Name of Patient (if not employee) for whom care will be provided (Last, First, MI)	If child, age of child ___________

B	HEALTH CARE PROVIDER COMPLETES SECTIONS B & C

Your patient or a family member of your patient is requesting medical leave. The specific information you provide will assist Eastern Washington University in determining the appropriate leave designation. Please complete Section B and be as specific as possible; terms such as “unknown,” or “as tolerated” may not be sufficient to determine their leave designation. Please fill out Section C. Failure to fully complete this form in a timely manner may lead to the delay or denial of the employee’s requested leave.

A “serious health condition” means an illness or injury, impairment, or physical or mental condition that involves one of the categories below:

Is patient’s condition a “serious health condition?” Yes No

If yes, please identify any of the following that are applicable to your patient:

- Inpatient care: (e.g. overnight hospital, hospice or residential medical care facility stay) Date(s) of admission: ____/____/____ through ____/____/____
- Incapacity of more than three (3) consecutive calendar days and includes:
  Two (2) or more treatments by HCP; with the first visit being within seven (7) days of the incapacity, and the second visit occurring within thirty days of the incapacity; or one treatment by HCP within seven (7) days and continuing regimen under HCP supervision.
- Chronic Serious Health Condition: A chronic Serious Health Condition is one which: requires periodic visits or treatments (at least twice per year) by HCP; continues over an extended period of time; e.g. physical therapy; and may cause episodic absences rather than continued incapacity.
- Permanent or Long-Term Condition: Condition which the period of incapacity itself is permanent or long-term and for which treatment may not be effective, but requires continuing supervision of an HCP.
- Multiple Treatments: Condition which would likely result in an incapacitation of more than three (3) consecutive calendar days absent medical treatment (including recovery from those treatments).

Medical facts: 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 regiment of continuing treatment, such as the use of specialized equipment that will assist in determining leave needs.

If the leave is requested for the care of a child over the age of 18 noted in Section A:
Is the child physically or mentally incapable of self-care? Yes No

Employee Name (Last, First, MI)

FULL-TIME/CONTINUOUS LEAVE

Will the employee/patient be medically incapacitated/require care for a single period of time? Yes No

Begin date of period of incapacity: ____/____/____

End date of period of incapacity, if known: _____/_____/____

If return to work date unknown, date of next evaluation: _____/_____/_____

REDUCED WORK SCHEDULE

Will the employee need a reduced work schedule? Yes No

If Yes, Begin date ____/____/____ through ____/____/____ date

Identify the part-time/reduced work schedule that is medically necessary: ______hour(s) per day; ______day(s) per week (e.g. May work 5 hours/day, 5 day/week)
Or describe:

INTERMITTENT/EPISODIC LEAVE

Will the condition(s) cause intermittent/episodic flare-ups that prevent the employee from performing their job functions or requiring the patient to obtain care? Yes No

If Yes, Begin date ____/____/____

Estimate the frequency and duration of episodic absences caused by flare-ups or follow-ups appointments that is medically necessary (e.g. 1 time per 2 months for 3-4 days per episode)

Frequency: _____time(s) per_____ week(s)_____month(s) Duration: _____hour(s) or _____day(s) per episode

Identify the number of months the employee may need intermittent/episodic leave (up to 12 months) ___________ Or describe:

C	**HEALTH CARE PROVIDER INFORMATION**	
I certify that the information provided on this form is true and correct to the best of my knowledge.		
Health Care Provider Name *(please print or type)*	Health Care Provider Signature	Date
Health Care Provider Street Address	City, State, Zip	
Type of Practice	Telephone	Fax

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. To comply with this law, we are asking that you do 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.”