Certification of Health Care Provider
(Attachment B)

Vermont General Assembly
Office of Legislative Human Resources

The Vermont General Assembly may require an employee seeking a leave of absence due to a serious health condition to submit a medical certification issued by the employee's health care provider. The employee will have 15 calendar days to provide the certification to the Office of Legislative Human Resources; if the employee fails to provide complete and sufficient medical certification, the leave request may be denied.

SECTION 1 – EMPLOYER

Employee Name: _____
First *MI* *Last*

Pronouns: _____

Employer Name: _____

Employee's Job Title: _____

Job Description Attached? _____

Employee's Regular Work Schedule: _____

Statement of the Employee's Essential Job Functions: _____

_____

Date Certification Requested *(mm/dd/yy)*: _____

Date Medical Certification Must be Returned by: _____

SECTION 2 – HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient or your patient's caregiver has requested a leave of absence due to a serious health condition, which requires that the employee submit a timely, complete, and sufficient medical certification to support the request. For the employer's purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves inpatient care or continuing treatment by a health care provider.

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You may, but are not required to, provide other appropriate medical facts, including symptoms, diagnosis, or any regimen of continuing treatment, such as the use of specialized equipment.

Employee Name: _____

Health Care Provider's Name: _____

Health Care Provider's Business Address: _____

_____

Type of Practice / Medical Specialty: _____

Telephone: _____ E-mail: _____

PART A: Medical Information

Limit your response to the medical condition(s) for which the employee is seeking a leave of absence. Your answers should be your best estimate based on your medical knowledge, experience, and examination of the patient. After completing Part A, complete Part B to provide information about the amount of leave needed.

1. Approximate date the condition started or will start: _____

2. Best estimate of how long the condition lasted or will last: _____

3. Check the boxes for the questions below, as applicable. For any box(es) checked, the amount of leave needed must be provided in Part B.

[ ] Inpatient Care: The patient (____ has been / ____ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____ .

[ ] Incapacity plus Treatment *(e.g. outpatient surgery)*: Due to the condition, the patient (___ has been / ____ is expected to be) incapacitated for more than three consecutive, full calendar days from _____ to _____.
The patient (___ was/___ will be) seen on the following date(s): _____.

The condition (___ has also/___ has not) resulted in a course of continuing treatment under the supervision of a health care provider *(e.g. prescription medication or therapy requiring special equipment).*

[ ] Pregnancy: The condition is pregnancy. List the expected delivery date: _____.

[ ] Chronic Conditions *(e.g. asthma, migraine headaches)*: Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

[ ] Permanent or Long-Term Conditions *(e.g. Alzheimer's, terminal stages of cancer)*: Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if the active treatment is not being provided).

[ ] Conditions Requiring Multiple Treatments *(e.g. chemotherapy treatments, restorative surgery):* Due to the condition, it is medically necessary for the patient to receive multiple treatments.

[ ] None of the above: If none of the above condition(s) were checked, no additional information is needed. Go to page 4 to sign and date the form.

4. If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks leave *(e.g. use of nebulizer, dialysis)*:

_____

_____.

PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based on 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 coverage.

5. Due to the condition, the patient (__ had/__ will have) **planned medical treatment**(s) *(e.g. psychotherapy, prenatal appointments)* on the following day(s):

_____.

6. Due to the condition, the patient (__ was/__ will be) **referred to other health care providers** for evaluation or treatment(s).

State the nature of such treatments: _____.

Provide your best estimate of the beginning date: _____.

Provide your best estimate of the end date: _____.

7. Due to the condition, it is medically necessary for the employee to work a **reduced schedule**. Provide your best estimate of the reduced schedule the employee is able to work.

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Start date:_____ End date: _____

The employee is able to work (e.g. days/week): _____.

8. Due to the condition, the patient (__ was/__ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery. Provide your best estimate of the beginning date _____ and end date _____ for the period of incapacity.

9. Due to the condition, it (__ was/__ is/__ will be) medically necessary for the employee to be **absent from work on an intermittent basis**, including for any episodes of incapacity i.e. episodic flare-ups. Provide your best estimate of how often and how long the episodes of incapacity will likely last.
Over the next six months, episodes of incapacity are estimated to occur _____ times per (__ day/__ week/__ month) and are likely to last approximately _____ (__ hours/__ days) per episode.

PART C: Essential Job Function

If provided, the employee's job description may be used to answer this question. If the job description is not attached, answer these questions based on the employee's own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be *not able* to perform the essential job functions of the position during the absence for treatment(s).

10. Due to the condition, the employee (__ was not able/__ is not able/__ will not be able) to perform *one or more* of the essential job functions. Identify at least one essential job function the employee is not able to perform:

_____

_____.

_____ _____
SIGNATURE OF HEALTH CARE PROVIDER DATE