

APPENDIX C
Medical Certification Form

CERTIFICATION OF PHYSICIAN OR PRACTITIONER

1. Employee's Name:		2. Patient's Name (if other than employee):	
Last	First	Middle	
3. Diagnosis:			
4. Date condition commenced:		5. Probable duration of condition:	
6. Regimen of treatment to be prescribed (indicate number of visits, general nature and duration of treatment including referral to other provider of health services; include schedule of visits or treatment, if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week.			
(a) By Physician or Practitioner			
(b) By another provider of health services, if referred by Physician or Practitioner			
If this certification relates to care for the employee's seriously ill family member, skip items 7, 8, and 9 and proceed to items 13 thru 22. Otherwise, continue below.			
Check Yes or No in the boxes below, as appropriate:			
7. Is inpatient hospitalization of the employee required? <input type="checkbox"/> Yes <input type="checkbox"/> No			
8. Is employee able to perform work of any kind? (If "No", skip item 9) <input type="checkbox"/> Yes <input type="checkbox"/> No			
9. Is employee able to perform the functions of employee's position? (Answer after reviewing statement from employer of essential functions of employee's position, or, if none provided, after discussing with employee) <input type="checkbox"/> Yes <input type="checkbox"/> No			
10. Signature of Physician or Practitioner		11. Date	12. Type of Practice (Field of Specialization, if any):