Unified Government of Athens-Clarke County
HR Benefits Fax: 706-224-2528

Certification of Health Care Provider

(Short Term Disability for Employee's own Medical Necessity)

(Adapted from ACCGov STD benefit eligibility requirements)

Important Notice for Heath Care Provider:
Title II of the Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers from requesting or requiring genetic information of employees or their family members. Certain exceptions apply including requests for family medical history to comply with the certification provisions of the FMLA or State or local family and medical leave laws, or pursuant to a policy that permits the use of leave to care for a sick family member that requires employees to provided information about the health condition of the family member to substantiate the need for leave. If this exception does not apply to this particular case, we ask that you not provide any genetic information when responding to this request for medical information. 'Genetic information," 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 legally held by an individual or family member using assisted reproductive technology.

1. Employee's Name:_____

2. Patient's Name (If different from employee):_____
   Address:_____
   Phone:_____

3. Does the Patient's condition[1] qualify under any of the categories described below?
   Yes_____ No_____

If yes, please check the category below:

____A serious health condition (including treatment therefor, or recovery therefrom) lasting more than three consecutive days.

____Pregnancy or prenatal care.

____A chronic serious health condition that continues over an extended period of time, requires periodic visits to a health care provider, and may involve occasional episodes of incapacity (e.g., asthma, diabetes).

____A permanent or long-term condition for which treatment may not be effective (e.g., Alzheimer's, a severe stroke, cancer).

____Absences to receive multiple treatments for restorative surgery or for a condition which would likely result in a period of incapacity of more than three days if not treated (e.g.,chemotherapy or radiation treatments for cancer).[2]

4. Describe the **medical facts,** which support your certification, including a brief statement as to how the medical facts meet the criteria of one of the above categories ("having surgery" is NOT an approved description, and may result in a *Denied* request):

_____
_____
_____
_____
_____
_____
_____

5. Is the Patient currently incapacitated?
   Yes_____ No _____
   If yes, list the date first incapacitated:_____

6. Date the Patient first consulted you: _____

7. State the approximate **date** the condition began, and the probable duration of the condition (and also the probable duration of the patient's present incapacity[1] if different):

_____
_____

8. Has the Patient ever had the same or similar conditions in the past?
   Yes_____ No _____
   If yes, please describe:_____
_____
_____

9. Will it be necessary for the Employee to take off work **ONLY** intermittently, or to work on a less than full schedule as a result of the condition, or for treatment(s) of the condition?
   Yes_____ No _____
   If yes, give the probable duration of a single treatment: _____
   If yes, give the est. number of required treatments: _____
   If yes, please describe the regimen of treatment (ex. P/T, Rx drugs): _____
_____
_____

10. If the condition is a **chronic condition** or **pregnancy**, state whether the Patient is presently incapacitated and the likely duration and frequency of **episodes of incapacity**: _____
_____
_____

11. Employee's own condition: If medical leave is required for the Employee's absence from work (including absences due to pregnancy or a chronic condition), is the Employee **completely incapacitated** and unable to perform work of any kind?
   Yes_____ No _____
   If no, please describe work ability, OR required restrictions including duration of limitation:
_____
_____
_____
_____

12. Care for Family Member: If **consecutive** dates of leave are required to care for a family member of the Employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation?
    Yes____ No ____
    If yes, indicate the duration of assistance required: _____

    If no, would the employee's presence to provide **psychological comfort** be beneficial to the patient or assist in the patient's recovery?
    Yes____ No ____
    If yes, indicate the duration of comfort required: _____

13. Care for Family Member: If **intermittent** dates of leave are required to care for a family member of the Employee will the patient care be required intermittently, or on a part-time basis?
    Yes____ No ____
    If yes, indicate the anticipated duration:_____
    If yes, indicate the anticipated schedule (if possible):_____
    _____
    _____

Signature of Health Care Provider (HCP)	Printed Name of HCP
Name of Practice	Date Form Completed
Street Address of Practice	HCP Phone Number
City, State, and Zip	HCP Fax Number

[1] Here and elsewhere on this form, the information sought relates only to the condition for which the employee is requesting/taking medical leave.

[2] "Incapacity," for purpose of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment thereof or recovery therefrom.