THE SCHOOL DISTRICT OF HERNANDO COUNTY, FLORIDA

CERTIFICATION OF PHYSICIAN OR PRACTITIONER

To be completed by physician

1. **Employee's Name**: ____________________________________ 2. **Patient's Name**: __________________________________
(If other than employee)

3. **Diagnosis & other relevant medical facts**: ____
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4. **Date Condition Commenced**: ________________________ 5. **Probable Duration of Condition**: __________________________

6. **Regimen of treatment prescribed** (*indicate number of visits, general nature and duration of treatment, including referral to other provider of health care 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**: ____
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B. **By another provider of health services, if referred by physician or practitioner**: _________________________________
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IF THIS CERTIFICATION RELATES TO CARE FOR THE EMPLOYEE'S SERIOUSLY ILL FAMILY MEMBER, SKIP ITEMS 7, 8, AND 9 AND PROCEED TO ITEMS 10 THROUGH 14; OTHERWISE CONTINUE BELOW.

Check Yes or No in the boxes below as appropriate:	YES	NO
7. **Is inpatient hospitalization of the employee required?**	☐	☐
8. **Is employee unable to perform any of his/her job functions?** (If yes, Item 9)	☐	☐

(Answer after reviewing job description, or if none is provided, after discussing with employee.)

9. **Identify the job functions the employee is unable to perform**: ____
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FOR CERTIFICATION RELATING TO CARE FOR THE EMPLOYEE'S SERIOUSLY ILL FAMILY MEMBER, COMPLETE ITEMS 10 THROUGH 14 BELOW AS THEY APPLY TO THE FAMILY MEMBER.

Check Yes or No in the boxes below as appropriate:	YES	NO
10. **Is inpatient hospitalization of the family member (patient) required?**	☐	☐
11. **Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?**	☐	☐
12. **After review of the employee's signed statement (see item 14 below), is the employee's presence necessary or would it be beneficial for the care of the patient?**	☐	☐

13. **Estimate the period of time care is needed or the employee's presence would be beneficial** ______________________________

ITEM 14 IS TO BE COMPLETED BY THE EMPLOYEE REQUESTING LEAVE.

14. **When leave is needed to care for a seriously ill family member, the employee shall state the care he or she will provide and an estimate of the time period during which this care will be provided, including a schedule if leave is to be intermittent or on a reduced leave schedule:** ____
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____ ____

Employee Signature Date **Physician or Practitioner's Signature Date**

____ ____

Type of Practice (Field of Specialization, if any) **Physician or Practitioner's Name, Address & Telephone Number**