Certification of Health Care Provider for

Employee's Serious Health Condition LOA Due to Covid-19

Employer Name:

Phone Number:

Employee's Job Title:

Work Site/Location:

Employee's essential job functions:

SECTION II: For Completion by the EMPLOYEE INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. Nutley Public Schools requires that you submit a timely, complete, and sufficient medical certification to support a request emergency paid sick leave as provided under the Families First Coronavirus Response Act or request to work remotely as a result of your compromising medical condition. Failure to provide a complete and sufficient medical certification may result in a denial of your request.

Your name:

SECTION III: For Completion by the HEALTH CARE PROVIDER INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested emergency paid sick leave as provided under the Families First Coronavirus Response Act or request to work remotely as a result of his/her compromising medical condition. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon 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. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee’s family members, 29 C.F.R. § 1635.3(b). Please be sure to sign the form on the last page.

Provider’s name and business address:

Type of practice / Medical specialty:

Telephone:

PART A: MEDICAL FACTS

1. **Questions:**

Approximate date condition commenced:

Probable duration of condition:

In accordance with Governor Murphy’s Restart and Recovery Plan for Education - Reasonable accommodations should be provided for individuals that the Centers for Disease Control identifies as having a higher risk for severe illness from COVID-19, including older adults (aged 65 years and older) and individuals with disabilities or serious underlying medical conditions, which include:

Check all that apply:

____ Chronic lung disease or asthma (moderate to severe)

____ Serious heart conditions

____ Immunocompromised

____ Severe obesity (body mass index, or BMI, of 40 or higher)

____ Diabetes

____ Chronic kidney disease undergoing dialysis

____ Liver disease

____ Other

Has the patient tested positive for Coronavirus (Covid-19)? Yes _____ No _____

Date test was conducted _____

Date results were known _____

In your professional medical opinion, can the patient work in their Nutley Public School work site if all CDC guidelines are followed and enforced, thus providing the staff member with safe working conditions? _____Yes _____ No, explain

Will the patient need to have regular treatment due to the condition? No_____ Yes _____

Was medication, other than over the counter medication, prescribed? No ____Yes._____

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., specialist)? _ No ____Yes._____

If yes, state the nature of such treatments and expected duration of treatment:

2. **Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.**

   Is the employee unable to perform any of his/her job functions due to the condition:
   No _____Yes_____.
   If yes, identify the job functions the employee is unable to perform:

3. Describe other relevant medical facts, if any, related to the condition for which the employee seeks to take a leave of absence (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

PART B: AMOUNT OF LEAVE NEEDED

4. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ____Yes.

If so, estimate the beginning and ending dates for the period of incapacity:

5. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ____No ____Yes.

If so, are the treatments or the reduced number of hours of work medically necessary? ____No ____Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Estimate the part-time or reduced work schedule the employee needs, if any: hour(s) per day; _____days per week from through

6. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? No____ _ Yes_____.

Is it medically necessary for the employee to be absent from work during the flare-ups?

____ No ____ Yes If so, explain:

_____

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency : times per week(s) month(s) Duration: _____hours or day(s) per episode

Doctor's Signature:

Date:

Employee's Signature:

Date: