Certification of Health Care Provider Form

Employee's Name:	Patient's Name (if different from employee)
Employee's Work Site:	Patient's Relationship to Employee:

To be Completed by Patient

I _____hereby authorize _____ (name of physician) , or any other physician(s) involved in my care, to release information regarding my physical condition relating to the injury/illness associated with the date of injury/illness listed above to Human Resources/Risk Management, and/or designee responsible for assessing leave requests. The information disclosed pursuant to this form shall be used solely for the purpose of evaluating the need and duration for requested leave. This authorization shall become effective immediately upon my signature and shall expire on the re-evaluation date listed below. I understand I have a right to receive a copy of this authorization.

Patient Signature_____ **Date**_____

To Be Completed by Physician -The information requested on this form relates only to the serious health condition for which the employee is requesting leave under the FMLA/CFRA. Please check the applicable category of the patient's qualifying condition.

☐ **Hospital Care** Admission to Hospital Date: _____ Discharge Date: _____

☐ **Acute Condition (Absence Plus Treatment)** From:_____ Through: _____

☐ **Birth of a Child** Estimated Date of Delivery _____

☐ Via Natural Birth ☐ Via Cesarean

☐ Request for Mother ☐ Request for Father

☐ **Chronic/Permanent** Expected frequency of absence: _____ days per month

Lasting _____ hours per absence or other:_____

1. Length of time your patient has, had, or will have this condition: From: _____ Through: _____

2. Explain the care needed by the patient and why the care medically necessary, please describe frequency and duration.

3. Describe the *regimen of treatment* to be prescribed indicating the number of visits, general nature and duration of treatment, including referral to other provider(s) of health services. (Include schedule of visits or treatment, if 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.

Name of Healthcare Provider **Type of Practice**

Street and Mailing Address

Telephone Number **FAX Number**

Physician Signature **Date**

Please return the completed form to:

VUSD Human Resources, 5000 W Cypress Ave. Visalia Ca 93277 or Fax 559-735-8099