AFTER PHYSICIAN HAS COMPLETED
PLEASE FAX TO THE BENEFITS OFFICE
@ (913) 993-6283
THANK YOU

CERTIFICATION OF PHYSICIAN OR PRACTITIONER
(Part-Time Health Leave)

1. Employee's Name:

2. 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.):

PLEASE COMPLETE QUESTIONS 7, 8, AND 9, RELATED TO EMPLOYEE'S CONDITION.

	Yes	**No**	
7.	___	___	Is inpatient hospitalization of the employee required?
8.	___	___	Is employee able to perform work of any kind? (If no, skip Item 9.)
9.	___	___	Is employee able to perform the functions of employee's position?

10. **Signature of Physician or Practitioner:**

11. Date: **12.** Type of Practice (Specialty):

13. **Signature of Employee:**

14. Date: