St. Mary Parish Schools

Certification of Absence Form for Psychiatric Disabilities

Must be completed by a Psychiatrist (MD or DO), Licensed Psychologist (PhD or PsyD)

Employee's Name _____ Employee ID Number _____

The following is to be completed by the healthcare provider.

Please list all DSM or ICD diagnoses (text and code)

Diagnoses _____

_____

Date diagnosed _____ Date patient was last seen _____

Evaluation

How did you arrive at this diagnosis? Please check all relevant items below, adding any notes that will help us to determine eligibility for leave or accommodations.

☐ Interviews with the patient _____

☐ Interviews with other persons _____

☐ Behavioral observations _____

☐ Neuropsychological testing _____

☐ Psychoeducational testing _____

☐ Other _____

Date of last evaluation _____

Functional Limitations

Please list all functional limitations that affect the patient's ability to perform his/her job.

_____

_____

_____

_____

Please list current medications and special considerations regarding side effects.

_____

_____

_____

_____

Please provide any additional information you feel will be useful in determining the patient's eligibility for leave or in determining appropriate accommodations.

_____

_____

_____

_____

Do you anticipate the patient may return to work with accommodations? _____

Please list the recommended accommodations below.

_____

_____

Certification of Absence

I certify there is a medical necessity for this patient to be absent from work beginning on this date: _____. Patient is able to return to work on _____.

Physician's signature (original required): _____

Printed name of physician: _____

Physician's address: _____

Date from was completed: _____