Certification of Health Care Provider for Employee's Serious Health Condition

Please have this form completed and returned within 15 calendar days to: Clay Community School Central Office
1013 S. Forest Ave., Brazil, IN 47834

Employee name:

Employee name:		
	Middle Initial)	(Last Name)
Employer name and contact: Clay Community Schools, 101	3 S Forest Ave. Bro	azil, IN 47834, Attn: HUMAN RESOURCE DEPT.
Employee's job title:		Regular work schedule:
Employee's essential job functions:		
For completion by the HEALTH CARE PROVIDER		
Provider's name and business address:		
Type of Practice / Medical Specialty:		
Telephone: ()	Fax: <u>(</u>)
Approximate date condition commenced/20_		Accident Other explain:
Probable duration of leave for this condition	Days	_ Week(s) Other:(explain)
Was patient admitted overnight in a medical care facility	/? Yes No	
Was the patient referred to another health care provide (e.g. physical therapist, surgeon, specialist, etc.)		If so, where- Treatment-
s employee unable to perform any of his/her job function	ons Yes	Date(s)- If so, list:
due to this condition?	No	
Will follow-up appointments be likely?	Yes No	If so, approx. how many and approx. duration:
Please describe other relevant medical facts, if any, relat (e.g. therapy, surgery, rehabilitation, etc.)	ted to the condit	ion for which employee seeks leave:
Signature of Health Care Provider		Date