WASHINGTON TOWNSHIP PUBLIC SCHOOLS
OFFICE OF HUMAN RESOURCES
206 EAST HOLLY AVENUE
SEWELL, NJ 08080

Certification of Health Care Provider

1. Employee's Name	2. Patient's Name (If different from employee)
3. Page 3 describes what is meant by a **"serious health condition"**. Does the patient's condition qualify under any of the categories described? If so please check the applicable category. (1) _____ (2) _____ (3) _____ (4) _____(5) _____ (6) _____ or None of the above _____	

4. Describe the **medical facts** which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

5. a. State the approximate **date** the condition commenced and probable duration of the condition.
b. If a medical absence from work is required for the employee (including absences due to pregnancy or a chronic condition), what physical/mental limitations are caused by the condition; (e.g. standing/sitting, lifting, etc.)?
c. State what treatment(s) the patient has received for the condition, to date. (e.g. prescription medications, physical therapy, chemo/radiation therapy, etc.)
d. State the frequency and duration of the treatment that was provided.
Here and elsewhere on this form, the information sought relates only to the condition for which the employee is absent from work.
"Incapacity" for purposes of medical absence, is defined to mean inability to work or perform other regular daily activities due to the health condition, treatment therefor, or recovery therefrom

6. a. If additional future **treatments** will be required for the condition, provide an estimate of the probable number of such treatments and probable date such treatments will be completed.
b. State any probable physical/mental limitations the future treatments may cause. Also provide an estimate of the probable number of and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any.
c. If any of these treatments will be provided by **another provider of health services** (e.g., physical therapist), please state the nature of the treatments.
d. **If a regimen of continuing treatment** by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

Signature of Health Care Provider

Type of Practice

Address

Telephone Number

Date

Employee Signature

Date

1. Hospital Care **Inpatient care** (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment (a) A period of incapacity of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

(1) **Treatment two or more times** by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or
(2) **Treatment** by a health care provider on **at least one occasion** which results in a **regimen of continuing treatment** under the supervision of the health care provider.

3. Pregnancy Any period of incapacity due to **pregnancy**, or for **prenatal care**.

4. Chronic Conditions Requiring Treatments

A **chronic condition** which:

(1) Requires **periodic visits** for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;

(2) Continues over an **extended period of time** (including recurring episodes of a single underlying condition); and

(3) May cause **episodic** rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-term Conditions Requiring Supervision

A period of **Incapacity** which is **permanent or long-term** due to a condition for which treatment may not be effective. The employee or family member must be **under the continuing supervision of, but need not be receiving active treatment by, a health care provider**. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. Multiple Treatments (Non-Chronic Conditions)

Any period of absence to receive **multiple treatments** (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for **restorative surgery** after an accident or other injury, **or** for a condition that **would likely result in a period of Incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment**, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), and kidney disease (dialysis).

Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.