State of Connecticut Human Resources

# Medical Certificate

Return to Agency Human Resources

Form #: P33A - Employee
Revision Date: 9/2018

To be used by employee who is absent for personal illness, including Family and Medical Leave Entitlements.

| | | |
|---|---|---|
| **AGENCY INFORMATION** | Agency Human Resources Representative | Agency Name |
| | Agency Address | |
| | Agency Phone Number | Agency Fax Number |
| **EMPLOYEE INFORMATION** | Employee's Name | Employee's ID Number |
| | Employee's Job Title | Department/Unit |

**INSTRUCTIONS TO THE HEALTH CARE PROVIDER**

**This form must be executed by a physician or practitioner whose method of healing is recognized by the State.**

Provide full, complete and legible answers to all questions. Several questions seek a response as to frequency and duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine coverage under the Family and Medical Leave Entitlements.

Limit your responses to the condition for which the employee is or will be absent from work. Do not provide information about genetic tests, as defined in 29 C.F.R. §1635.3(f), genetic services, as defined in 29 C.F.R. §1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. §1635.3(b).

If additional space is needed, please attach a separate sheet and identify the question number. Please be sure to sign the form on page 3.

**MEDICAL FACTS**

1. Reason for employee's absence:

| | |
|---|---|
| ☐ **Employee's illness or injury** | ☐ **Organ donor** |
| ☐ **Incapacity related to employee's pregnancy and childbirth**<br>Expected Due Date:_____ | ☐ **Bone marrow donor** |

2. Approximate date condition commenced: _____

3. Probable duration of the condition: _____

4. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ☐ NO ☐ YES

   If YES, dates of admission: _____

5. Is it medically necessary for the patient to receive continuing treatment by a medical provider? ☐ NO ☐ YES

If YES, provide the following information about the treatment:

- Dates you treated the patient for the condition: _____
- Will the patient need to have treatment visits at least twice per year due to the condition? ☐ NO ☐ YES
- Was medication, other than over-the-counter medication, prescribed? ☐ NO ☐ YES
- Was the patient referred to other health care provider(s) for evaluation or treatment? ☐ NO ☐ YES
- Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave. Include, as applicable, a description of relevant symptoms, information about the referral(s) to other health care provider(s), and the regimen of continuing treatment or the plan for continuing supervision provided by the health care provider for a condition for which treatment may not be effective.

6. Is the employee unable to perform any of his/her job functions due to the medical condition (including the need for treatment and recovery)? ☐ NO ☐ YES

If YES, identify the job functions the employee is unable to perform (using the employee's job specification, if provided, as a reference).

**LEAVE NEEDED**

1. Is it medically necessary for the employee to be absent from work due to his/her medical condition, including the need for treatment and recovery? ☐ NO ☐ YES
2. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ☐ NO ☐ YES

If YES, estimate the beginning and ending dates for the period of incapacity:

Beginning Date: _____ Ending Date: _____

3. Is it medically necessary for the employee to attend follow-up treatment appointments because of the medical condition? ☐ NO ☐ YES

   If YES, provide the actual or estimated treatment schedule. Include the dates of any scheduled appointments, the time required for each appointment, and any recovery period:

4. Is it medically necessary for the employee to work on a reduced schedule due to the employee's condition? ☐ NO ☐ YES

   If YES, estimate the reduced work schedule needed by the employee:

   ____ hours per day

   ____ days per week

   From _____ through _____

5. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☐ NO ☐ YES

   If YES: Is it medically necessary for the employee to be absent from work during the flare-ups? ☐ NO ☐ YES

   If YES, explain:

6. Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

   - Frequency: ____ times per ____ week OR ____ times per ____ month
   - Duration: ___ hours per episode OR _____days per episode

| Name of Physician or Practitioner *(please type or print)* | Physician or Practitioner License Number |
|---|---|
| Address | |
| Phone Number | Fax Number |
| Signed *(Physician or Practitioner)* | Date |

# EMPLOYEE FITNESS-FOR-DUTY CERTIFICATION

The employee's treating health care provider must complete this fitness-for-duty certification.

The employee must provide the completed fitness-for-duty certification to Human Resources **before** reporting to his or her department or unit.

| Employee's Name | Employee's ID Number |
|---|---|
| Employee's Job Title | Department/Unit |

I have examined _____ and certify that he/she is able to return to work.
(employee's name)

Date the employee will be able to return from leave: _____

Will the employee have any restrictions when he or she returns to work?: ☐ NO ☐ YES

If YES, describe the restrictions (If additional space is needed, please attach a separate sheet):

| Name of Physician or Practitioner *(please type or print)* | Physician or Practitioner License Number |
|---|---|
| Address | |
| Phone Number | Fax Number |
| Signed *(Physician or Practitioner)* | Date |