Directions: To be completed by the licensed physician or health practitioner of the employee needing shared leave. Must attest to the severe or extraordinary nature and expected duration of the condition, or the condition of the relative or household member of the employee, as defined by the District in Board policy 5406.

Port Townsend School District
1610 Blaine St Port Townsend WA 98368
Personnel Office: (360) 680-5755

CERTIFICATION OF HEALTH CARE PROVIDER for SHARED LEAVE

1. Employee's Name (please print) _____

2. Patient's Name (if other than employee) _____

3. Port Townsend School District Board Policy Procedure 5406 defines "severe or extraordinary" as "serious or extreme and/or life threatening".

4. Describe the medical facts that support your certification, including a brief statement as to how the medical facts meet the criteria of "severe or extraordinary".

5.a. State the approximate date the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present incapacity if different).

b. Will it be necessary for the employee to take work only intermittently or to work on a less than full schedule as a result of the condition (including for treatment described in Item 6 below)? Yes _____ No _____ If yes, give the probable duration.

6.a. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments.

If the patient will be absent from work or other daily activities because of treatment on an intermittent or part-time basis, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery, if any.

b. 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.

c. 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).

7.a. If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind? Yes _____ No _____

b. If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job (the employee or the employer should supply you with information about the essential job functions)? Yes _____ No _____
If yes, please list the essential functions the employee is unable to perform.

c. If neither a. nor b. applies, is it necessary for the employee to be absent from work for treatment? Yes _____ No _____

8.a. If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation? Yes _____ No _____

b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? Yes _____ No _____

c. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need.

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule.

_____ _____
Signature of Health Care Provider Type of Practice

_____ _____
Address Telephone Number

_____
Date