MEDICAL CERTIFICATION FORM

Return this form via Fax: 225-218-4020

Email: medcert@ebrschools.org (Subject Line: Employee's Name)

This section to be completed by the EMPLOYEE DATE: ___________________________

EMPLOYEE'S NAME: ____ LOCATION: ______________________

EMP # OR SOCIAL: _____________________ POSITION: ____

EMAIL: ____ CONTACT PHONE: ______________________________

FMLA LEAVE REQUESTED: ☐ Yes ☐ No ☐ Uncertain **PATIENT**: ☐ Self ☐ Family Member

Name of Patient ___________________________________ Relationship: ____________________

LEAVE TYPE REQUESTED: ***Check all that Apply***

☐ Sick Leave ☐ Extended Sick Leave ☐ Maternity Leave

☐ Leave Without Pay ☐ Military Leave ☐ Intermittent Leave

☐ Initial Request ☐ Leave Extension #1 ☐ Leave Extension #2

I authorize my health care provider to provide written and verbal information to the East Baton Rouge Parish School System regarding myself or my family member's medical condition to determine my eligibility for employee leave. I understand that I must have written clearance from the below health care provider to be submitted to my employer clearing me to return to work after treatment.

Employee's Signature: ____ Date: __________________________

TO BE COMPLETED BY A **HEALTH CARE PROVIDER** – Please fill out the information below fully and completely, all applicable parts.

PATIENT'S NAME: ____ ☐ Employee ☐ Family Member

Diagnosis/Condition: ____

1. Is it medically necessary for the above employee/patient to be absent from work? ☐ Yes ☐ No
2. Is in-patient hospitalization of the patient required? ☐ Yes ☐ No
3. Is the employee able to perform work of any kind? ☐ Yes ☐ No
4. Is the condition considered catastrophic illness? ☐ Yes ☐ No
5. Is the medical condition Pregnancy? ☐ Yes ☐ No If yes, expected delivery date: _____________

LEAVE DATES: *Begin: _____________________________ *End: ___________________________________

**Beginning date should be the 1st date of leave and the ending date should be the last date of leave. This form will not be processed without beginning and ending dates.*

Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

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Physician's Name: _______________________________ Address: ____

Professional License Number: ____ Issuing State: ________________

Phone Number: ________________________________ Email Address: _______________________________________

Physician's Signature: ____ Date: _____________________

This form can be mailed to: EBRPSS Office of Human Resources P.O. Box 2950 Baton Rouge, LA 70821-2950

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