

Office of  
Human Resources  
215-683-6950

FIRST JUDICIAL DISTRICT OF PENNSYLVANIA  
**MEDICAL CERTIFICATION**  
**Non-FMLA Events Only**



(For FMLA events, see next page)

**Instructions to Employee: RETURN COMPLETED FORM(S) TO YOUR IMMEDIATE SUPERVISOR.**

In accordance with the policy of the First Judicial District of Pennsylvania, this form must be completed by the treating licensed health care provider when: (a) a non FMLA-qualifying personal illness or injury has resulted in your absence for more than two (2) consecutive work days; or (b) in accordance with "Sick Leave Abuse" provisions, past sick leave use requires certification for each new sick leave occurrence.

**HEALTH CARE PROVIDER:** Please provide the information requested below and sign in the space at the bottom of this form. Thank you for your cooperation.

Employee Name: \_\_\_\_\_

was  is under my professional care from \_\_\_\_/\_\_\_\_/\_\_\_\_ through \_\_\_\_/\_\_\_\_/\_\_\_\_.  
(Date) (Date)

Having examined this individual, it is my opinion that he/she:

- may return to work with no restrictions.
- may return to work with restrictions described in "Prognosis" section below.
- may not be expected to return to work until \_\_\_\_/\_\_\_\_/\_\_\_\_.  
(Date)
- Return unknown. Next medical evaluation on \_\_\_\_/\_\_\_\_/\_\_\_\_.  
(Date)

**PROGNOSIS:** Please provide the prognosis, any short term restrictions or limitations placed on the employee, and the duration of such restrictions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**The District reserves the right to determine whether limitations or restrictions can be reasonably accommodated.**

Please **PRINT** the following information:

Physician's name: \_\_\_\_\_ Telephone number: \_\_\_\_\_

Address: \_\_\_\_\_

*The undersigned Physician/licensed Health Care Provider hereby verifies that the statements made herein are true and correct to the best of his/her knowledge, information, and belief.*

\_\_\_\_\_  
Signature of Physician/Health Care Provider

\_\_\_\_\_  
Date

*I understand that making false or misleading statements will subject me to disciplinary action up to and including discharge.*

\_\_\_\_\_  
Employee signature

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

# FAMILY AND MEDICAL LEAVE EVENTS

(Complete only if FMLA is applicable)

**Instructions to Employee: RETURN COMPLETED FORM(S) TO YOUR IMMEDIATE SUPERVISOR.**

In accordance with the policy of the First Judicial District of Pennsylvania, this form must be completed by the treating licensed health care provider when FMLA leave is being requested for a personal or family member's serious health condition.

**HEALTH CARE PROVIDER:** Please provide the information requested below and sign in the space at the bottom of this form. Thank you for your cooperation.

Employee Name: \_\_\_\_\_ Patient Name: \_\_\_\_\_

I. The employee above qualifies for FMLA leave due to:

- Family Care** - For the care of a parent, spouse, or child with a qualifying (see below) serious illness or injury, or to care for a new born child or a child placed in the home due to adoption or foster care within the previous 12 months. [Relationship of patient to employee: \_\_\_\_\_]
- Hospital Care** - Inpatient care of at least one overnight stay in a hospital, hospice, or residential medical care facility including any period of incapacity or subsequent treatment relating to such inpatient care.
- Absence plus Treatment** - A period of incapacity of more than three consecutive days that also involves: (1) two or more treatments by a health care provider or prescribed health service provider; or (2) at least one treatment by a health care provider followed by continuing treatment under the supervision of the health care provider.
- Pregnancy** - Any period of incapacity due to pregnancy or prenatal care.
- Chronic Conditions Requiring Treatment** - A chronic condition which: (1) requires periodic visits for treatment by health care provider or prescribed health service provider; (2) continues over an extended period of time, including recurring episodes of an underlying condition; or (3) may cause episodic rather than a continuing period of incapacity (e.g., asthma).
- Permanent/Long Term Conditions Requiring Supervision** - Patient must be under continuing supervision of, but not necessarily treatment by, a health care provider due to a permanent or long-term incapacity (e.g., Alzheimer's, severe stroke, or terminal stages of a disease).
- Multiple Treatments (non-chronic conditions)** - Absence due to treatment for restorative surgery after an illness or surgery or for a condition that left untreated would result in incapacity of more than three consecutive days (e.g., chemotherapy, dialysis, etc.).

II. Date the condition commenced: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ If known, date employee may return to work: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Date Date

If return date is unknown, date of next medical evaluation: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Date

III. **If follow-up treatment is required**, please indicate the following:

- 1. Type of treatment (medication, therapy, etc.): \_\_\_\_\_
- 2. Number of treatments: \_\_\_\_\_
- 3. Frequency of treatments: \_\_\_\_\_

IV. **If leave is for the employee's own medical condition**, is the employee able to perform work of any kind?  Yes  No  
If yes, what essential job functions is the employee unable to perform (employee can describe general tasks):

Will the employee be required to work an intermittent or shortened work schedule?  Yes  No  
If yes, what is the probable duration of the altered work schedule? \_\_\_\_\_

If a chronic condition or pregnancy, is the patient currently incapacitated?  Yes  No  
If yes, what is the likely duration and frequency of episodes of incapacity? \_\_\_\_\_

V. **If leave is required to care for a family member**, what will be the nature of employee's assistance? Please check all that are applicable:  Medical or Personal assistance;  Safety;  Transportation;  Psychological Comfort;  Other assistance

Please **PRINT** the following information:

Physician's name: \_\_\_\_\_ Telephone number: \_\_\_\_\_

Address: \_\_\_\_\_

The undersigned Physician/licensed Health Care Provider hereby verifies that the statements made herein are true and correct to the best of his/her knowledge, information, and belief.

\_\_\_\_\_  
Signature of Physician/Health Care Provider Date

I understand that making false or misleading statements will subject me to disciplinary action up to and including discharge.

\_\_\_\_\_  
Employee Signature Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_