THE UNIVERSITY of MONTANA WESTERN

MEDICAL CERTIFICATION

A University of Montana employee who requests family and medical leave due to a serious health condition may be required to provide medical certification. An employee is not required to obtain medical certification for the first six calendar weeks of leave following childbirth.

MEDICAL CERTIFCATION FORMS ARE MAINTAINED IN FILES SEPARATE FROM GENERAL EMPLOYEE PERSONNEL RECORDS AND ARE TREATED AS CONFIDENTIAL MEDICAL RECORDS IN ACCORANCE WITH THE AMERICANS WITH DISABILITIES ACT AND THE FAMILY AND MEDICAL LEAVE ACT OF 1993.

SECTION 1: TO BE COMPLETED BY THE EMPLOYEE

Employee Name: _____ Social Security No.: _____
Department: _____ Division: _____
Location: _____ Position Title: _____

Briefly explain the reason for leave: _____
_____
_____

I hereby authorize (physician's name) _____ to provide information to The University of Montana Western regarding my and/or my dependent's (if the employee is requesting leave to care for a seriously ill child, spouse, or parent) medical condition, disability, illness, or injury and my ability to work.

_____ _____
Employee Signature Date

SECTION 2: TO BE COMPLETED BY THE PHYSICIAN

1. Explain the medical condition, disability, illness, or injury for which the patient is being treated:
_____
_____
_____

2. Prescribed treatment (for example: number of visits, general nature and duration of treatment, including referral to other provider of health services): _____
_____
_____

3. Is inpatient hospitalization required? _____ Yes _____ No

IF THIS CERTIFICATION IS RELATED TO CARE FOR THE EMPLOYEE'S SERIOUSLY ILL FAMILY MEMBER, PLEASE SKIP ITEMS 4 THROUGH 9 AND PROCEED TO ITEM 10.

4. Is the employee able to perform the functions of his/her position? (The employer may provide and request your review of a description of the employee's position. Otherwise, such information may be obtained through a discussion with the employee). _____ Yes _____ No

5. Will the employee's work activities need to be limited upon return to work?
_____ Yes _____ No
If yes, list a tentative date employee may resume work on a limited or restricted basis and recommended duration of limited work assignment: _____
_____

6. List duties or activities the employee is able to perform: _____
_____
_____

7. List any other restrictions (such as hours of work): _____
_____
_____

8. Will any activities or duties be limited permanently? _____ Yes _____ No
If yes, please explain: _____
_____

9. What is the tentative date the employee may resume with no limitations? _____

PLEASE COMPLETE ITEMS 10 THROUGH 15 FOR CERTIFICATION RELATING TO CARE FOR THE EMPLOYEE'S SERIOUSLY ILL FAMILY MEMBER.

10. Patient's name: _____

11. Is inpatient hospitalization required? _____ Yes _____ No

12. Does (or will) the patient require assistance for basic medical hygiene, nutritional needs, safety or transportation? _____ Yes _____ No

13. Is the employee's presence necessary or would it be beneficial for the care of the patient? (This may include providing psychological comfort or providing other basic needs such as hygiene, nutrition, safety or transportation.) _____ Yes _____ No

14. Estimate the period of time that care is needed or during which the employee's presence will be beneficial:
_____

15. Prescribed treatment (for example: number of visits, general nature and duration of treatment, including referral to other provider of health services): _____
_____
_____

If you have any additional comments, please attach them and check here: _____

_____ _____
Physician's Signature Date

_____ _____
Physician's Address Business Phone Number

Please return this form to:

University of Montana Western
Human Resource Services
Box 115
71 S. Atlantic St.
Dillon, MT 59725