TEANECK BOARD OF EDUCATION
HUMAN RESOURCE MANAGEMENT

Certification of Health Care Provider for
Employee's Serious Health Condition
LOA Due to Covid-19

Employer Name: _____

Phone Number: _____

Employee's Job Title:_____

Work Site/Location: _____

Employee's essential job functions: _____

_____

Check if job description is attached:

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. Teaneck Public Schools requires that you submit a timely, complete, and sufficient medical certification to support a request emergency paid sick leave as provided under the Families First Coronavirus Response Act or request to work remotely as a result of your compromising medical condition. Failure to provide a complete and sufficient medical certification may result in a denial of your request.

Your name: _____ _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested emergency paid sick leave as provided under the Families First Coronavirus Response Act or request to work remotely as a result of his/her compromising medical condition. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or 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. Limit your responses to the condition for which the employee is seeking leave. 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). Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____)_____Fax:(_____)_____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Mark below as applicable:

In accordance with Governor Murphy's Restart and Recovery Plan for Education - Reasonable accommodations should be provided for individuals that the Centers for Disease Control identifies as having a higher risk for severe illness from COVID-19, including older adults (aged 65 years and older) and individuals with disabilities or serious underlying medical conditions, which include:

Check all that apply:

____ Chronic lung disease or asthma (moderate to severe)
____ Serious heart conditions
____ Immunocompromised
____ Severe obesity (body mass index, or BMI, of 40 or higher)
____ Diabetes
____ Chronic kidney disease undergoing dialysis
____ Liver disease
____ Other

Has the patient tested positive for Coronavirus (Covid-19)? Yes _____ No _____

Date test was conducted _____

Date results were known _____

In your professional medical opinion, can the patient work in their Teaneck Public School work site if all CDC guidelines are followed and enforced, thus providing the staff member with safe working conditions?

_____Yes _____ No, explain

_____

_____

Will the patient need to have regular treatment 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 (e.g., specialist)?
____No ____Yes. If so, state the nature of such treatments and expected duration of treatment:

_____

2. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon

the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition: ____ No ____ Yes.

If so, identify the job functions the employee is unable to perform:

_____

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

_____

_____

_____

_____

_____

PART B: AMOUNT OF LEAVE NEEDED

4. 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 so, estimate the beginning and ending dates for the period of incapacity: _____

5. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? No ___Yes.

   If so, are the treatments or the reduced number of hours of work medically necessary?
   ___No ___Yes.

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

   Estimate the part-time or reduced work schedule the employee needs, if any:

   _____ hour(s) per day;_____days per week from_____through _____

6. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____No ____Yes.

   Is it medically necessary for the employee to be absent from work during the flare-ups?
   ____ No ____Yes If so, explain:

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(s)_____month(s)

Duration:_____hours or____day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**