BRILLION PUBLIC SCHOOLS
POLICY 532.31
Form B-Surgery

Family and Medical Leave Request Health Care Provider Certification

I, _____, state that _____
(Name of Health Care Provider - Print) (Patient's Name - Print)

is under my care for an illness or injury, impairment, or physical or mental condition involving (check the appropriate box):

☐ Inpatient care in a hospital, hospice, or residential medical facility; and/or

☐ Period of incapacity requiring:

- Absence from work, school, or other regular activities;
- For more than three (3) calendar days; **and**
- Involving continuing treatment or supervision by a health care provider during such period of time;

☐ Continuing treatment by (or under the supervision of) a health care provider for a chronic or long-term health condition that is incurable or so serious that it may result in a period of incapacity of more than three (3) calendar days; or

In addition, I certify that the patient is one of the following (Check the appropriate box):

☐ An employee of the School District of Brillion;

☐ The spouse of an employee;

☐ The son or daughter of an employee;

☐ The parent of an employee.

☐ The parent-in-law of an employee.

Accordingly, I certify that:

- I will perform _____ surgery on the above-named on _____, 20__.

- The surgery (is) (is not) medically necessary (circle which is applicable). Explain.

  _____

  _____

- The surgery (is) (is not) of an emergent nature such that the date of the scheduled surgery may not be postponed without serious health risk (circle which is applicable). Explain.

  _____

  _____

- Following surgery, the above-named is expected to recover sufficiently to return to his employment by _____, 20__. [anticipated recovery time may be extended if circumstances warrant].

- The patient was first seen by me relative to, and treated for, the condition now requiring surgery on _____.

- I have provided care to the patient on the following date(s). (List all dates of treatment or supervision):

  _____

- The surgery will be on an (inpatient) (outpatient) basis (circle which is applicable).

- The medical facts regarding the serious health condition are as follows, including the notice of the condition, a specific description of the surgery, and the medical necessity of such care:

  _____

  _____

  _____

The surgery and corresponding recovery time must render the employee unable to perform the functions of his or her position which means the employee is unable to work at all or unable to perform one or more of the essential functions of the position. Attached is a Job Description of the position of the employee.

- I have read the employee's job description and am aware of the job functions required for this employee to perform the functions of the position.

  Below is an explanation of the extent to which the employee is unable to perform the functions of the position as a result of the health condition for the entire recovery period noted above.

  _____

  _____

  _____

Dated this _____ day of _____, 20 _____.

_____ _____

Signature of Health Care Provider Telephone Number

_____ _____

Address City/State

Reviewed: 7/20/09