

**Certification of Physician
For Use of the Sick Leave Pool**

1. **Employee's Name:** _____
2. **Patient's Name (if other than the employee):** _____
3. **Relationship (family member to employee):** _____
4. **Diagnosis:**

5. **Prognosis:**

6. **Date condition began:** _____
7. **Probable duration of condition:** _____
8. **Expected recovery date:** _____
9. **Is inpatient hospitalization required?** Yes No
10. **Is employee able to perform work of any kind?** Yes No
11. **If illness or injury is a family member, is continual care needed for this individual?**
 Yes No

If yes, what amount of continual care is needed? Does the patient need someone to stay with them:

24 hours per day

Frequently during the day (8 – 12 hours)

Intermittently during the day (2 – 4 hours)

Occasionally during the day (1/2 hr – 2 hrs)

What are the projected dates continual care will be needed?

From: _____ **To:** _____

Signature of Physician: _____

Date: _____

Type of practice (field of specialization, if any): _____