Maryland's Largest School District

MONTGOMERY COUNTY PUBLIC SCHOOLS

MONTGOMERY COUNTY PUBLIC SCHOOLS Maryland

CLEAR FORM

MCPS Form 440-35
June 2024

Certification of Physician or Health-care Provider

MONTGOMERY COUNTY PUBLIC SCHOOLS
Employee and Retiree Service Center (ERSC) • 45 West Gude Drive, Suite 1200, Rockville, Maryland 20850 • ersc@mcpsmd.org

PART I: PATIENT INFORMATION—To be completed by employee.

Employee: _____ Employee No. 0000_____Date____/____/_____
Last *First* *MI*

PART II: FOR CERTIFICATION RELATING TO THE EMPLOYEE'S OWN SERIOUS HEALTH CONDITION—To be completed by the physician or health-care provider to verify services.

Estimated dates of absence: From ____/____/_____ through ____/____/_____
(Beginning and end dates must be specific and must coincide with days of leave of absence. If an end date cannot be specified, please state this and enter date of next appointment.

Regimen of Treatment to be Prescribed: (Indicate number of visits, general nature and duration of treatment, including referral to other provider of health services. Include schedule of visits or treatment if it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week.)

INFORMATION RELATING TO THE EMPLOYEE'S OWN SERIOUS HEALTH CONDITIONS.

Date condition commenced: ____/____/_____

State diagnosis and regimen of treatment to be prescribed: _____

_____

_____

_____

1. ❑ Yes ❑ No Is inpatient hospitalization of the employee required?
2. ❑ Yes ❑ No Is leave related to pregnancy? Provide estimated due date ____/____/_____.

PART III: FOR CERTIFICATION RELATING TO CARE FOR THE EMPLOYEE'S SERIOUSLY ILL FAMILY MEMBER—To be completed by physician or health-care provider to verify services.

Employee's family member: _____ Relationship to employee:_____
Last *First*

Employee's estimated dates of absence: From ____/____/_____through ____/____/_____

3. ❑ Yes ❑ No Is inpatient hospitalization of the family member (patient) required?
4. ❑ Yes ❑ No Does (or will) the patient require assistance for basic medical, hygiene, or nutritional needs, or for safety or transportation?
5. ❑ Yes ❑ No Is the employee's presence necessary or would it be beneficial for the care of the patient? (This may include psychological comfort.) If Yes:

Describe care needed: _____

_____

_____

Estimate the period of time care is needed or the employee's presence would be beneficial. Include a schedule if leave is to be taken intermittently or on a reduced-leave schedule.

_____

_____

_____

PART IV: AUTHORIZATION—To be completed by physician or health-care provider to verify services.

Print Name of Physician or Health-care Provider_____Phone _____-_____-_____

Signature, Physician or Health-care Provider _____Date____/____/_____

Type of Practice/Field of Specialization_____

If question is required concerning this case:
Print Name of Contact Person _____Phone _____-_____-_____