Certification of Healthcare Provider – Employee's Own Serious Condition

Section I - To be completed by Employee		
Employee/Patient Name:	Employee Job Title:	
Employer Phone: **866.475.0317 x11841**	Employer Fax: **888-204-5071**	Employer Email: **Loa@zovio.com**
☐ Check if job description listing essential functions is attached.		

Section II - To be completed by Health Care Provider	
Name of Health Care Provider:	Place office stamp here:
Address:	
Phone:	

INSTRUCTIONS TO HEALTHCARE PROVIDER: Your patient (our employee) has requested a medical leave of absence. Please 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 employee. Limit your responses to the condition for which the employee is seeking leave. Be sure to sign and date the form on page 2 and return prior to the due date.

THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA):
The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Note: Do not disclose the employee's underlying diagnosis without his/her consent.

Part A: Medical Facts

1. Approximate date condition commenced: ____________________ Pregnancy related? ☐ No ☐ Yes
   If pregnancy related condition, please provide expected due date (EDD/EDC): __________________ ☐ n/a

   Probable duration of condition: _______________________

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

   ☐ No ☐ Yes If yes, date(s) of admission: ___________________________________

   Date(s) you treated the patient for condition: ____

   Will the patient need to have treatment periodically 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 (i.e. physical therapist)?
   ☐ No ☐ Yes If yes, state the expected duration of treatment: ___________________________________

2. Use the information provided by Bridgepoint Education in Section I to answer these questions. If no job description has been provided, please answer these questions based upon the employee's own description of his/her job functions.

Is the employee able to perform work of any kind? ☐ No ☐ Yes

If yes, is the employee unable to perform one or more of the essential functions of his/her position due to the condition? ☐ No ☐ Yes

If yes, list the job functions the employee is unable to perform (i.e. bending, stooping, squatting, sitting):

____

____

Part B: Amount of Leave Needed:

Continuous Period of Time

3. 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 yes, please estimate the beginning *and* ending dates for the period of incapacity below:

   The anticipated duration of incapacity: ________________________ through ______________________

   Start Date Estimated End Date

Intermittent or Reduced Schedule

Answer questions 4 and 5 only if the employee requires leave on an intermittent or reduced schedule basis

4. Will it be medically necessary for the employee to leave work intermittently or work a reduced schedule as a result of the medical condition (other than for episodic flare-ups which are addressed in question #5 below)? ☐ No ☐ Yes

   If the employee needs reduced schedule leave, estimate the part-time or reduced schedule the employee needs: Hours per Day: ______ Days per Week: _______ From:____________ through_____________

   If the employee needs intermittent leave, estimate the frequency of need for intermittent leave and the duration of incapacity (i.e. 1 episode every 3 months lasting 1-2 days):

   Frequency: Times per Month ______ Times per Week ______

   Duration Per Episode: Hours per Day ______ Days per Episode ______

5. Will the medical condition cause episodic flare-ups that will make it medically necessary for the employee to leave work intermittently or work a reduced schedule? ☐ No ☐ Yes

   If yes, based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups, the likely duration of incapacity that the patient may have as a result, and the period during which the flare-ups may occur (i.e., 1 episode every 3 months lasting 1-2 days):

   Frequency: Times per Month ______ Times per Week ______

   Duration Per Episode: Hours per Day ______ Days per Episode ______

   Flare Ups may occur from ____________________ through _________________________

Notice: Before returning to work for a leave taken for the employee's own serious health condition, the employee is required to provide a healthcare provider's certificate stating that the employee can safely perform the essential functions of their job, with or without accommodation. Please complete the Return to Work form at that time to clear them to return.

Health Care Provider's Signature

Signature: Date: