JACKSON PUBLIC SCHOOLS
Transforming lives through excellent education

PHYSICIAN CERTIFICATION FORM

When completed, this form should be returned to the employee and **NOT the Jackson Public School District**.

1. Employee's Name:_____

2. Patient's Name:_____

3. The definition section on Page 2 describes what is meant by a "catastrophic injury or illness" under the Miss. Code Ann. §37-7-307 and the Jackson Public School District's Donation of Leave Policy GADEB. Does the patient's condition* qualify under the definition described?

4. Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of a catastrophic injury or illness.

5. Explanation of Illness or Injury:

   a. State the beginning date of the catastrophic illness or injury and the anticipated date the employee may return to work.

   _____

   b. State the prognosis for recovery.

   _____

   c. Will it be necessary for the employee to take work only intermittently or to work on a less than full schedule as a result of the condition (including for treatment described in Item 6 below)?_____

   If yes, give the probable duration:_____

   d. If the condition is a chronic condition, state whether the patient is presently incapacitated** and likely duration and frequency of episodes of incapacity.*

6. If the employee's absence from work is required because of the employee's own condition, is the employee unable to perform his/her job? (Employee should supply you with information about his or her job.)

7. Description of Care Needed:

   a. If leave is required to care for an immediate family member (spouse, parent, step parent, sibling, child, or step child) of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation?

   b. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need: _____

_____
Signature of Health Care Provider

_____ _____
Printed Name of Health Care Provider Type of Practice

_____ _____
Address Telephone Number

To be completed by the employee needing family leave to care for a family member:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

_____ _____
Employee Signature Date

* Here and elsewhere on this form, the information sought relates only to the condition for which the employee is requesting donated leave.

** "Incapacity" for purposes of Donated Leave is defined to mean total inability to work, attend school or perform other regular daily activities due to the catastrophic injury or illness, treatment therefore, or recovery there from.

Definition: **"Catastrophic Injury or Illness"** means life-threatening injury or illness of an employee or a member of an employee's immediate family that incapacitates the employee from work, as verified by a licensed physician, and forces the employee to exhaust all leave time earned by that employee, resulting in the loss of compensation from the school district for the employee. Conditions that are short-term in nature, including, but not limited to, common illnesses such as influenza and the measles, and common injuries, are not catastrophic. Chronic illnesses or injuries such as cancer or major surgery that result in intermittent absences from work, are long-term in nature, and require long recuperation periods may be considered catastrophic.