Horry County Schools

MEDICAL CERTIFICATION STATEMENT

Please return form to Natasha Montgomery in Human Resources
Phone: 843-488-6559 Fax: 843-488-7754 Email: nmontgomery@horrycountyschools.net

Section 1: TO BE COMPLETED BY EMPLOYEE

Name of the Employee: _____ Employee SS#: _____

Job Title: _____

SECTION II: PROVIDED BY EMPLOYER

Employee's essential job functions are attached to this application.

SECTION II: For Completion by the HEALTH CARE PROVIDER

Date the condition began: _____

Date the condition ended (or is expected to end): _____

1. Please list **PRIMARY** diagnosis and medical facts regarding the condition: (PLEASE BE SPECIFIC AS POSSIBLE):
   _____
   _____
   _____
2. Explanation of extent to which employee is unable to perform the functions of his or her job:
   _____
   _____
   _____
3. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   _____No _____Yes
   If so, dates of admission: _____
4. Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.
   If so, please list any medications currently prescribed for the patient that could affect their physical or mental abilities to perform the essential functions of their job.
   _____
   _____
   _____
5. Is the medical condition pregnancy? _____No _____Yes. If so, expected delivery date: _____
6. Using the attached job description is the employee unable to perform any of his/her job functions due to the condition: ____ No ____ Yes.
   If so, identify the job functions the employee is unable to perform:
   _____
   _____
   _____
7. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):
   _____

_____
_____

8. 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? Yes_____ No _____
   If so, estimate the beginning and ending dates for the period of incapacity: _____
9. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments:
   _____
   _____
   _____
10. If the employee's condition does not limit his/her ability to perform work, is it necessary for the employee to be absent from work for treatment?
    _____
    _____
    _____

_____ _____

Health Care Provider Signature **Health Care Provider's Name (Please print)**

License Number: _____ **Date:** _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ **Fax :**(_____) _____

Medical Release:

I authorize the release of any medical information necessary to process the above request.

Patient Signature: _____ Date: _____