



## Health Care Provider Certification (HCPC) For Medical Leave

*Must print in Black or Blue ink ONLY*

<b>Employee ID/SSN</b>	<b>Last Name, First Name</b>	<b>Department</b>
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### Section A – To Be Completed By Employee

**I am requesting medical leave from CMS as specified below:**

<b>Medical Leave Requested for</b> <input type="checkbox"/> Employee <input type="checkbox"/> Immediate Family	<b>Requested Leave</b> <input type="checkbox"/> Full Leave <input type="checkbox"/> Intermittent Leave
<b>Patient's Name</b> <i>(If leave is for a family member)</i>	<b>Patient's Relationship to Employee</b> <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child

#### AUTHORIZATION TO OBTAIN INFORMATION

I authorize any physician, medical professional, hospital, clinic, other medical care institution, Medical Information Bureau, insurer, consumer reporting agency, or employer having information available as to other insurance coverage, medical care, advice, treatment or supplies with respect to any physical or mental condition or any other information regarding me, to give the information to Charlotte-Mecklenburg Schools Benefits Office.

I understand that this information will be used by Charlotte-Mecklenburg Schools Benefits Office to determine eligibility for benefits and insurance. I agree this authorization is valid for two years from the date shown below. I know that my legally authorized representative or I have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original.

<b>Employee Signature</b>	<b>Date</b>
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### Section B - To Be Completed By Health Care Provider

<b>Date of Injury/Illness</b>	<b>Est. Return to Work Date</b>	<b>Diagnosis</b>
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**Please check Yes or No for each question below:**

<input type="checkbox"/> <b>Yes</b>	<input type="checkbox"/> <b>No</b>	Is it necessary for the employee to be absent from work for treatment or family care?
<input type="checkbox"/> <b>Yes</b>	<input type="checkbox"/> <b>No</b>	Does the employee or family member have a health condition requiring either inpatient care or treatment by a physician or other health care provider? If yes, indicate the treatment schedule: _____
<input type="checkbox"/> <b>Yes</b>	<input type="checkbox"/> <b>No</b>	Is it medically necessary for the employee to be on leave for self or to assist a family member with basic hygiene, nutrition, safety, transportation, or psychological comfort? If yes, indicate the dates: From: _____ To: _____
<input type="checkbox"/> <b>Yes</b>	<input type="checkbox"/> <b>No</b>	Is it medically necessary for the employee to work fewer than his/her normal scheduled hours or days? If yes, specify: Hours per day: _____ Days per week: _____
<input type="checkbox"/> <b>Yes</b>	<input type="checkbox"/> <b>No</b>	Will the employee be able to return to a normal work schedule? If yes, indicate anticipated return to work date: _____

<b>Health Care Provider Name</b>	<b>Health Care Provider Stamp</b>	
<b>Address, City, State, Zip</b>		
<b>Health Care Provider Signature</b>	<b>Telephone</b> (    )	<b>Date</b>

*DISTRIBUTION: Original – City View, ATTN: Benefits Coordinator 1609 Alleghany St., Charlotte, NC 28208    FAX: 980-343-3996*