U.S. Virgin Islands Division of Personnel

Donated Leave Medical Re-Certification

The Government of the Virgin Islands Donated Leave Program allows government employees to donate sick or annual leave to eligible co-workers who have experienced a serious health condition and have exhausted their own paid leave balances. This employee is requesting an extension to their current Donated Leave Request, or an updated Medical Certification form has been requested after the employee has participated in the donated leave program over 480 hours. Please complete this form to substantiate the continuing need for leave. *Your answers should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; "lifetime," unknown," or "indeterminate" may not be sufficient to determine eligibility.*

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.

Section I (to be completed by the employee):

Name	Employee Number	
Job Title	Department	Regular Work Hours
Essential Job Duties		

Reason for Re-certification:

☐ Recertification requested by the Division of Personnel after 480 hours
☐ Leave extension request for the same serious health condition
☐ Leave request for a different serious health condition (PLEASE DO NOT COMPLETE THIS FORM, A NEW MEDICAL CERTIFICATION IS REQUIRED)

I have provided the physician below with my original signed Medical Certification. I hereby authorize my physician to release the following information to the Division of Personnel and to answer related questions from Division of Personnel employees who evaluate Donated Leave requests to help determine if the identified medical condition(s) continue(s) to meet the definition of a serious medical condition which is defined below.

Signature	Date

Section II (to be completed by the attending health care provider):

Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answers should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," unknown," or "indeterminate" may not be sufficient to determine eligibility. Please be sure to sign and date the form on the last page.

Physicians Name	Degree	Type of Practice/ Medical Specialty
Practice Name		Practice Phone
Practice Address		

Patient Name	Patient Date of Birth	Patient Relationship to Employee
		☐Self ☐Spouse ☐Sibling ☐Parent ☐Child Age ____ ☐Other_____

Date of last medical visit	ICD-9 or DSM-IV Code (including any complications)
Diagnosis Narrative	Objective Symptoms

Please check indicate the appropriate update for the patient's serious condition:

Hospitalization & Surgery

Has this patient been hospitalized since the last medical certification or re-certification.
Name of Hospital _____ Address of Hospital _____ City _____ State_____

Dates of Hospitalization: From ____/____/_____through ____/____/_____ Period of incapacity following release _____ ☐day(s) ☐week(s) ☐month(s)

Dates of Surgery: From ____/____/_____through ____/____/_____ Period of incapacity following surgery _____ ☐day(s) ☐week(s) ☐month(s)

Patient Progress

☐Recovered ☐Improved ☐Unchanged ☐Retrogressed Is Patient ☐Bed Confined ☐Hospital Confined ☐Ambulatory ☐House Confined ☐None

Limitations in an 8-hour workday (please check one box per row)

	0 hours	Up to 2.5 hours	Up to 5.5 hours	Greater than 5.5 hours
Climb				
Balance				
Stoop				
Kneel				
Crouch				
Crawl				
Reach				
Walk				
Sit				
Stand				
Use Hands				
	Sedentary (10 lbs. maximum, walking occasionally)	Light (20 lbs. maximum, 10 lbs. frequently)	Medium (50 lbs. maximum, 25 lbs. frequently, up to 10 lbs. constantly)	Heavy (100 lbs. maximum, 50 lbs. frequently, 20 lbs. constantly)
Lift				
Carry				
Push				
Pull				
	Class 1 No Limitation	Class 2 Slight Limitation	Class 3- Marked Limitation	Class 4 Complete Limitation
Cardiac				
	Comment			
Mental Impairment				

Based on your selection(s) above, after reviewing the employees essential job duties and based on the employee's own description of his or her essential functions:

Will the patient need Continuing Treatment? ☐Yes ☐No If so, please provide the dates of treatment ____/_____/_____ through ____/_____/_____

Description of treatment _____Frequency _____

Will treatment or an episodic flare up require a recovery period? ☐Yes ☐No Recovery Period after each _____ ☐day(s) ☐week(s) ☐month(s)

Will treatment significantly improve employability of this employee? ☐Yes ☐No If yes, describe treatment _____

Will the employee be permanently prevented from performing their essential job functions even with a reasonable accommodation? ☐Yes ☐No

If Yes, will the employee be able to perform another type of job? ☐Yes ☐No If Yes, describe _____

This patient can work with an accommodation, please indicate the type of accommodation(s) needed for the employee to return to work:

☐permanent accommodation ☐temporary accommodation ____/_____/_____ through ____/_____/_____ If provided, the employee may return on ____/_____/_____

Accomodation:_____

If no accommodation exists, or the employer is unable to provide the requested accommodation, and the employee is not permanently prevented from performing their essential job functions, the employee will be unable to complete their essential job functions from ____/_____/_____through ____/_____/_____.

Please state the essential functions the employee is unable to complete _____.

Optional Remarks _____

If this request for a family member	Please indicate the type of assistance or primary care to be provided: ☐Medical Assistance ☐Psychological Support ☐Transportation ☐Assistance with activities of daily living ☐Other _____ Will the employee need to provide assistance and primary care for the patient during the work hours indicated above? ☐Yes ☐No If yes, will that assistance be provided: ☐full time or ☐part time ____/_____/_____ through ____/_____/_____
Physicians Signature	Date