U.S. Virgin Islands Division of Personnel

Donated Leave Medical 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 Medical Certification form must be completed to substantiate the need for leave.

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 Leave:

☐ Bonding leave following the birth or placement of my child
☐ My serious health condition that affects my ability to complete the essential functions of my job (including pregnancy complications)
☐ Military Injury/Illness
☐ Serious health condition of family member or other individual who is my legal dependent that affects my ability to complete the essential functions of my job

If requesting leave due to my own serious health condition, I confirm that I have provided my physician with a description of my essential job duties. 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) meet(s) 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 answer 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_____

Approximate date the condition commenced	Probable duration of the condition
ICD-9 or DSM-IV Code (including any complications)	Probable duration of incapacity
Diagnosis Narrative	
Objective Symptoms	

Please check the box to indicate the appropriate category for the patient's condition:

☐ Hospital Care

Inpatient care (i.e. overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

Dates of Hospitalization: From____/____/_____through____/____/_____Period of incapacity following release_____☐day(s) ☐week(s) ☐month(s)

☐ **Absence Plus Treatment**

A period of incapacity of more than five consecutive workdays (including any subsequent treatment or period of incapacity relating to the same condition, that also involves:

☐ Treatment two or more times by a health care provider by a nurse or physician's assistant under direct supervision of a health care provider or by a provider of health care services (i.e. physical therapists) under orders of or on referral by a health care provider;

☐ Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of a health care provider.

☐ **Pregnancy**

☐ A period of incapacity due to pregnancy, childbirth or pregnancy related conditions Patient's expected delivery date____/_____/_____

☐Bonding time following the birth of a child (12-week FMLA maximum) Patient's actual delivery date____/_____/_____

☐ **Chronic Conditions Requiring Treatment**

☐ Requires periodic visits for treatment by a health care provider, or by nurse or physician's assistant under direct supervision of a health care provider

☐ Continues over an extended period of time (including recurring episodes of a single underlying condition)

☐ May cause episodic rather than continuing period of incapacity (e.g. Asthma, diabetes, epilepsy etc.)

☐ **Multiple Treatments (Non-Chronic Conditions)**

Any period of absence to receive multiple treatments including any period of recovery therefrom by a health care provider or by a provider of health care services under orders of or on referral by a health care provider either for restorative surgery after an accident or other injury or for a condition that would likely result in a period of incapacity for more than five workdays in the absence of medical intervention or treatment such as cancer (radiation/chemotherapy) severe arthritis (physical therapy) or kidney disease (dialysis).

☐ **Permanent Long-Term Conditions Requiring Supervision**

A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The employee must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include: Alzheimer's, a severe stroke, or the terminal stages of a disease.

Will the employee be permanently prevented from performing their essential job functions with a reasonable accommodation? ☐Yes ☐No If no, please indicate the type off accommodation(s) required for the employee to return to work.

_____ If

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

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

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

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)

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: Can employee be released to work with or without reasonable accommodations?

☐Yes, work restrictions noted below ☐No, essential functions of the job that cannot be performed are noted below

_____

If the above accommodations are provided the employee may return to work on____/____/_____. If no accommodation exists, or the employer is unable to provide the requested accommodation, the employee will be unable to complete their essential job functions from____/____/_____through____/____/_____.

Your answers should be your best estimate based upon your medical knowledge, experience, and examination of the patient.

False or misleading medical certifications are subject to 14 V.I.C. Ch. 41 Fraud and False statements (§§ 831 — 852). Be as specific as you can; "lifetime," unknown," or "indeterminate" may not be sufficient to determine eligibility.

Optional Remarks_____

Physicians Signature	Date