ROLLINS COLLEGE
HUMAN RESOURCES DEPARTMENT
Family Medical Leave Act (FMLA)
Short-Term Disability (Salary Continuation Benefit)
Staff/Faculty Parental Leave
Certification of Health Care Provider Form (CHCP)

Dear Medical Provider:

Rollins College is very interested in the health and well being of its employees. As a family-friendly employer, the College provides income protection, through its short-term disability program, to eligible employees during periods of incapacity.

Your patient has requested leave under the FMLA and the College's short-term disability program. To receive short-term disability pay and benefits through the College, the employee must submit a completed *Certification of Health Care Provider Form (CHCP)* from their medical provider. Under no circumstances will short-term disability payments be provided without appropriate certification.

To this end, the College requests that you complete the enclosed CHCP. This information will be used to:

- Assess the employee's ability to perform the essential functions of their job
- Serve as a basis for determining the employee's eligibility for disability pay and benefits in accordance with College policy

<u>The College requires that an employee on leave to submit an updated CHCP every 30 days to determine continued eligibility for disability pay and benefits in accordance with College policy</u>.

Answer, fully and completely, all applicable parts of the attached CHCP Form. 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 FMLA coverage or eligibility for short-term disability benefits. Please be sure to sign the form on the last page.

The College feels it is important to create an environment that allows ill or injured employees an opportunity to recover to their maximum potential. In some instances, the College may be able to accommodate work restrictions and allow an employee to return-to-work in a light duty capacity.

We appreciate the high quality of medical care that you provide and do not wish to compromise the medical treatment. Should you have any concerns or require additional information, please feel free to contact me directly. Thank you in advance for your assistance.

Regards,

Jennifer Addleman
Benefits Administrator
Rollins College
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Winter Park, Florida 32789-4499
Phone: 407-975-6453
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CERTIFICATION OF HEALTH CARE PROVIDER FORM (CHCP)

(Required to Determine Eligibility for College Salary Continuation Benefits)

EMPLOYEE AUTHORIZATION TO RELEASE INFORMATION

Employee/Patient's Name:	
R-Number:	
Social Security Number:	Home Phone Number:
Work Phone Number:	Cell Phone Number:
Home Address:	
Department/Position Title:	
Last Day Worked:	

I hereby authorize the undersigned Physician or any of it agents to release any information acquired in the course of my examination and treatment to Rollins College and/or its agents. This includes data in reference to the duration of any work disability and return to work. A copy of this authorization is to be considered valid.

Patient Signature: ____

Date: ____

ATTENDING PHYSICIAN'S STATEMENT

The requested information will be used to assess the employee's ability to perform their essential job functions and will serve as a basis for determining eligibility for disability pay in accordance with College policy. Please provide the most current medical update as of the date you are completing/signing this documentation.

1. What is the **medical diagnosis** & **corresponding ICD-9 diagnostic code(s)**?

2. Is the **condition** (please circle): *Temporary* *Permanent* *Progressive* *Chronic*

3. Is the medical condition **pregnancy**? *Yes* *No* If Yes, **Expected Delivery Date**: ___________

4. State the **approximate date** the condition commenced, and the **probable duration** of the condition below:

   Approximate **date** the condition(s) commenced (mm/dd/yyyy): ________________________________

   New Condition/First Time Reporting:

   Probable duration of the condition (months, weeks or days): ________________________________

   Continuing/Ongoing Condition Previously Reported (as of signing this form):

   Probable duration of the condition **as of today** (months, weeks or days): ______________________

5. Was the **patient admitted** for an overnight stay in a hospital, hospice, or residential care facility (Please circle)? *Yes No*

   If Yes, **dates of admission** & when you treated patient: ______________________________________

   Will patient need to have treatment visits **at least twice per year** due to condition? *Yes No*

   Was **medication**, other than over-the counter medication, **prescribed**? *Yes No*

6. Is the patient **presently incapacitated**[1] or is a **future period** of **incapacity anticipated?** (Please circle)? *Yes No*

   a. If **Yes**, what **date** did/will the **incapacity start** (mm/dd/yyyy): ____________________________

   b. If **Yes**, give the **probable duration of incapacity** as of today (months, weeks or days):

   ____

   c. Will patient be **incapacitated** for a **single continuous period of time** due to medical condition including any time for **treatment and recovery**? *Yes No*

7. During the period of **incapacity**, is the employee able to **perform any work at all** (please check)?

   ☐ **No**, requires complete absence from work. Please provide the **medical facts** supporting this conclusion:

   ☐ **Yes**, regular work schedule with some functional restriction(s) and/or limitation(s)

   ☐ **Yes**, reduced work schedule, with some functional restriction(s) and/or limitation(s)

   ☐ **Yes**, reduced work schedule, with no functional restriction(s) and/or limitation(s)

   Please **identify job functions** patient is **unable to perform** and the **functional restriction(s) and/or limitation(s)** that exist, please **list**:

[1] "Incapacity" is defined to mean inability to work, attend school or perform other regular daily activities due to the condition, treatment therefor, or recovery therefrom.

If **reduced work schedule** exists:

How many **hours** will the employee be **able to work**: ________**per day** ________**per week**

Please give the **probable duration**: ____________________________

8. Will the condition cause **episodic flare-ups periodically** preventing the patient from performing his/her job functions? *Yes No*

9. Is it **medically necessary** for the patient to be **absent from work during flare-ups**? *Yes No*

   If Yes, please **estimate the frequency** of flare-ups and the **duration of related incapacity** that the patient may have **over the next 6 months** (e.g. 1 episode every 3 months lasting 1-2 days)

   Frequency: _____ times per _____week(s) _____ months(s)

   Duration: _____ hours or _____ day(s) per episode

10. Please **describe** the **treatment plan** below:

11. What **medications** have been **prescribed**?

12. If additional **treatment(s)** will be **required** for the condition:

    a. Provide an **estimated number** of treatment(s):____

    b. Provide an **estimate of the interval** between treatments: ________________________________

    c. Provide the **time period required** for recovery from treatment(s):__________________________

13. Provide a general description of any **regimen** (e.g. prescription drugs, physical therapy requiring special equipment) if **continuing treatment** is **required** under your supervision:

14. Please state the **nature of the treatments** if any of these treatments will be provided by **another provider of health services** (e.g. physical therapist):

15. Is it **necessary** for the employee to be **absent from work for treatment**? *Yes* *No*

If **Yes**, please explain why below:

Medical Provider Name (Printed)

Type of Practice

Signature of Medical Provider

Date Signed

Address

Telephone Number

Fax Number