CARROLL HOSPITAL CENTER

Leave of Absence for Medical Reasons Request

Complete this portion of form and indicate if you will be collecting short-term disability.

General Information	Associate Name: _____ Associate ID: _____ Address: _____ _____ Phone Number: _____ Position: _____ Number of hours scheduled per pay: _____ **Will you be filing a claim to collect short term disability?** _____
Type of Leave	I request _____ day(s) of leave, beginning _____ through _____. I have read and fully understand the information contained on this form and in the Leave of Absence for Medical Reasons Policy. **Associate Signature:** _____ **Date:** _____
Medical Information Release (if applicable)	**I authorize the release to or by Carroll Hospital Center, Inc. of any medical or other information required to process my claim for short-term disability or personal medical leave of absence. A photocopy of this authorization may be honored.** **Associate Signature:** _____ **Date:** _____

Received in HR on**:** _____ Received By: _____

Leave of Absence for Medical Reasons
Attending Provider Certification

This entire form is to be completed by a licensed provider.

Patient's **Diagnosis**	Patient's Name: _____ Primary Diagnosis: _____ Is the condition due to: ☐ an accident ☐ an injury Date symptoms appeared or accident occurred: _____ Was a surgical procedure performed? ☐ Yes ☐ No If yes: Describe Procedure: _____ Date: _____ If pregnancy, what is the estimated date of delivery? _____ Actual Delivery Date: _____ Type of Delivery: _____
Treatment Information	Is the patient currently under your treatment for this condition? _____ Date patient became unable to substantially perform his/her usual work duties?_____ Date of first visit? _____ Date of most recent visit? _____ Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other: _____
Extent of Disability	Is patient currently disabled, unable to substantially perform work duties? _____ I have reviewed the Physical Requirements and Essential Functions of the Associate's job? _____ If yes, when do you think the patient will be able to return to work? _____ Is the patient able to perform any type of work with or without restrictions? _____ If yes, please describe type of work and or restrictions: _____ _____
Provider Certification	**Please return the completed form to the patient or to:** Carroll Hospital Center 200 Memorial Avenue Westminster, MD 21157 Attn: Human Resources Fax Number: 410.871.6989 Licensed Provider Name: _____ Phone #: _____ Provider Signature: _____ Date: _____