

SHARED LEAVE PROGRAM CERTIFICATION OF HEALTH CARE PROVIDER

STATE OF NORTH DAKOTA

SFN 62270 (01-2023)

The Shared Leave Program for the State of North Dakota allows state employees, hereafter known as "team members", to donate accrued leave to a fellow team member who is suffering from or who has a household or family member who is suffering from a severe or extraordinary illness, injury, impairment or physical or mental condition that has caused, or is likely to cause, the team member to take leave without pay or terminate employment. The team member is required to provide a medical certification only from a physician, physician assistant, psychologist, or nurse practitioner verifying the serious, extreme, or life-threatening nature of the medical condition and the expected duration of the condition.

SECTION I - COMPLETED BY THE TEAM MEMBER

Please complete the team member section of the form before providing this form to the health care provider. Failure to provide a complete and sufficient medical certification may result in the denial of your request for Shared Leave.

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Team Member Name			Agency Name						
Job Title			Regular Work Schedule						
Only complete below if you are caring for a family member with a severe or extraordinary illness, injury, impairment or physical or mental condition:									
Family Member Whom You Will Provide Care:									
Child, under age 18 (I Child, age 18 or older Other* - specify:	tive, foster or stepparent) natural, adoptive, foster or and incapable of self-care	because of a	mental or physical disability (natura	•					
Briefly describe the care you will provide to the family member and the reason(s) you will need to be absent from work (attach additional sheet(s), if necessary):									
4. Best Estimate of Leave Hours Needed to Care for Family Member									
5. If a reduced work schedu	le is necessary to provide o	described care	e, provide estimate of reduced work	schedule	below.				
Dates of Reduced Work Schedule: From: To:			Hours Per Day Available to Work	Days Per Week					
SECTION II - COMPLETED BY HEALTH CARE PROVIDER									
Health Care Provider's Name			Type of Practice/Medical Specialty						
Health Care Provider Address		City		State	ZIP Code				
Telephone Number	Fax Number	Email Address							

PART A: Medical Information

The information you provide is for the medical condition(s) for which the state team member is seeking Shared Leave. The State of North Dakota's Shared Leave Program is intended to allow team members to assist each other with leave donations to help cope with severe, extraordinary, extreme and/or life-threatening health crises. Donated leave is intended to help team members in these circumstances to bridge unexpected absences that they do not have paid leave to cover, and which would cause them to go into unpaid status for a period of time. Your answers should be your best estimate based upon your medical knowledge, experience, and examination of the patient.

Examples of "extraordinary or severe" situations that are typically approved include:

• Major surgery with inpatient hospital stay; cancer and treatment; hospitalization for a severe physical or mental condition; enrollment in an ongoing behavioral health treatment program (inpatient or day) requiring continuous leave from work.

Examples of Conditions that are typically not approved include:

• Flu; chicken pox; COVID-19, sprained ankle; elective cosmetic surgery; intermittent leave for chronic, ongoing medical conditions.

Approximate Date Condition Started/Will Start		2. Best Estimate of Time Condition Will Last				
3. F	or Shared Leave to apply, care of the patient must be medically eeded by patient.	ed Leave to apply, care of the patient must be medically necessary. Provide a summary of the medical condition and care y patient.				
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4 D	loes the condition substantially limit major life activities?					
+. Ե	No Yes - Describe:					
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•	ome examples of major life activities include, but are not limited seeing, hearing, eating, sleeping, walking, standing, lifting, ben thinking, communicating, working, caring for oneself, performin	ding, speaking, breathing, learning, reading, concentrating,				
dı		be how the team member is restricted as to the condition, manner, or pared to the way in which an average person in the general population				
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6. Cl	heck all applicable box(es) below. For all box(es) checked, the	·				
a.	Inpatient Care: The patient ☐ has been ☐ is e residential medical care facility on the following date(s)	expected to be admitted for an overnight stay in a hospital, hospice, or it.				
b.	Due to the condition, the patient has been is e calendar days from: (mm/dd/yyyy) to: The patient was will be seen on the following the condition has has not also resulted in a condition will be seen on the following the condition will be seen will be seen on the following the condition will be seen will be seen will be seen on the following the condition will be seen will be seen on the following the condition will be seen will	ndar days from: (mm/dd/yyyy) to: (mm/dd/yyyy). patient was will be seen on the following date(s):				
C.	Pregnancy: If the condition is pregnancy related, list Normal pregnancy, without serious complications, is no					
d.		Chronic Conditions: (e.g. asthma, migraine headaches) Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.				
e.		Permanent or Long Term Conditions: (e.g. alzheimer's, terminal stages of cancer) Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).				
f.	Conditions requiring Multiple Treatments: (e.g Due to the condition, it is medically necessary for the p					

PART B: Amount of Leave Needed

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

7. Due to the condition, the patient: had will have planned, scheduled medical treatment/visit(s), (e.g. psychotherapy, prenatal appointments)									
Date(s) of	Date(s) of Scheduled Medical Visit(s)								
8. Due to the was	8. Due to the condition, the patient: was will be referred to other health care provider(s) for evaluation or further treatment.								
Nature of 1	Nature of Treatment (e.g. cardiologist, physical therapy)								
Treatment	Begin Date	End Date	Best Estimate for Duration of Treatment (including recovery), e.g. 3 days/week for x weeks)						
	9. Due to the condition, it is medically necessary for the team member to work a reduced schedule. Provide your best estimate of the reduced schedule the team member is able to work:								
Date to Be	gin Reduce	d Schedule	Date to End Reduced Schedule	Hours Team Member	Able to Work (5hrs/day, 25hrs/wk)				
10. Due to the was	10. Due to the condition, the patient: was will be incapacitated for a continuous period of time, including any time for treatment(s) and/or recovery.								
Incapacitat	ed Begin D	ate	Estimated Release Date						
11. Due to the condition, it: is was will be medically necessary for the team member to be absent from work on an intermittent basis (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your best estimate of how often (frequency) and how long (duration) the episodes of incapacity will likely last. Over the next 6 months, episodes of incapacity are estimated to occur:									
Estimated	Instances (times)	Per	Likely to Last (approx	imate duration) ☐ Days (per episode)				
Signature of He	alth Care P	rovider			Date				