CDI CONTRACTORS

CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE'S COVID-19 EMERGENCY LEAVE

Employer name and contact: ____

Employee's name: ______________________________

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested Covid-19 Emergency Leave under the Families First Coronavirus Response Act. Please complete this form based upon your medical knowledge, experience, and examination of the patient. Please be sure to sign and date below.

<u>REASONS FOR LEAVE</u>

Please select the reason(s) below for which the employee is unable to work or telework:

□ I have advised this patient to self-quarantine due to concerns related to COVID-19.

□ This patient is experiencing COVID-19 symptoms and has sought a medical diagnosis.

□ This patient is experiencing another substantially similar condition as specified by the Secretary of Health and Human Services. (Please identify the applicable condition: ______________________).

Date(s) you treated the patient for this condition: _____________________

Estimate the beginning and ending dates for the period of incapacity: ________________________

Health Care Provider's name and business address: ____

Telephone: (____)______________ Fax:(____)______________

____ ____

Signature of Health Care Provider **Date**