PHYSICIAN'S CERTIFICATE OF INJURY/ILLNESS (PCII)

SANDIA PROPRIETARY INFORMATION
Personal Identifiable Information (when completed)

Instructions to Employee:
Sickness absence benefits provide for temporary leave for diagnosed medical conditions with a goal of assisting employees in successfully returning to work. To qualify for paid sickness absence benefits and to allow Sandia to determine your eligibility for leave under the Family Medical Leave Act (FMLA) or California Family Rights Act (CFRA), please follow these instructions**.** Failure to comply may result in denial of sickness absence benefits and/or denial of FMLA leave. NOTE: FMLA designated for your own illness/injury will run concurrently with Sickness Absence.

You are required to submit this form when you:

- have been absent for a full work week or 7 consecutive calendar days,
- have had surgery and/or were under general anesthesia (exceptions: colonoscopies, laser eye surgery and routine dental and dermatology procedures *without* complications),
- have been admitted to the hospital,
- have been absent due to a heart or psychiatric condition,
- require medical restrictions,
- apply for FMLA/CFRA for your own serious health condition (completing FMLA/CFRA section)
- are requested to submit a PCII by your manager and/or Employee Health Services,
- need an extension to a current sickness absence or FMLA/CFRA leave for your own health condition
- are on a plan that requires a PCII for all absences.

The PCII must be received by HR Benefits within 15 calendar days of the first date of absence. You must be seen by your personal provider or an Urgent Care facility within the first five full consecutive workdays or seven full consecutive calendar days of absence to have this form completed. The PCII must be complete or sickness absence benefit time may be denied. *Sandia Medical will only complete this form under rare circumstances.*

Review the full Sandia policy for sickness absence, paid family leave, FMLA/CFRA:
HR018 Sickness Absence, Paid Family Leave, FMLA and CFRA Policy

In addition to reviewing the policy in full, it is important to be aware you there are restrictions on your outside activities (including but not limited to):

- cannot have outside employment during sickness absence
- cannot travel 100 miles outside of your area without prior approval from EHS
- cannot engage in activities hindering recovery

You are required to maintain contact with your manager throughout your absence as directed.

Please return this form to:

- HR Solutions
  - FMLA eForm on hr.sandia.gov
  - Email: fmlasub@sandia.gov
  - Fax: (505) 845-1046

SF 4560-G (5-2023)
Supersedes (11-2019)

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Employee Information - *To be completed by employee*

Name:	SNL ID:	DOB:
Org:	Work Phone:	Union: ☐ MTC ☐ SPA ☐ OPEIU
Best Contact Phone:	Personal email:	
Was this illness/injury the result of a accident? ☐ Yes ☐ No	What was the cause of that accident? Briefly describe: (e.g. MVA, fall, fire, etc.)	

Authorization for Release of Medical Information

Required for paid leave under *HR018 Sickness Absence, Paid Family Leave, and FMLA policy;* Not Required for Determining FMLA Benefits

Your Authorization for Release of Medical Information **WILL NOT** be used in evaluating your eligibility for FMLA benefits. However, providing this authorization is required in order to be approved for paid sickness absence leave under HR018 ***Sickness Absence, Paid Family Leave, and FMLA policy***.

I authorize any physician, medical practitioner, health care provider, hospital, Veterans Administration hospital, clinic, other medical or medically related facility having information as to diagnosis, treatment, and prognosis with respect to any physical or mental condition, and/or treatment of me related to this absence/illness only, to provide Sandia National Laboratories' Employee Health Services any and all such information. This authorization does not extend to genetic information and no genetic information should be provided. I understand that the information obtained by use of this Authorization will be used by Sandia National Laboratories' Employee Health Services to determine eligibility for sickness absence benefits. I understand that I have the right to revoke this authorization in writing at any time. This authorization will expire on _____ or one year from date of signature.

☐ I acknowledge I have read HR018 Sickness Absence, Paid Family Leave, and FMLA Policy.

☐ I authorize Sandia to use my personal email address for communications regarding this request.

Employee Signature:	Date:

Occupational Medical Information - *To be completed by medical provider*

First Date of Absence:	Date First Seen:	Date Last Seen:
Diagnosis:		ICD10:
Hospitalization/Surgery:		Date(s) of surgery or hospitalization:

If restrictions:	With or without restrictions:
☐ Restrictions only ☐ Or Return to Work Date (modified or restricted duty): _____	☐ Return to Work Date (full, unrestricted duty): _____ ☐ Or date of next evaluation: _____

Restrictions (may attach additional documents as necessary):	Start Date	End Date

Provider Information - *To be completed by treating medical provider*
Additional signature box required for FMLA

Health Care Provider's name and credentials: (Print)

Health Care Provider's business address:

Phone:	Fax:	Email:

By signing this, I CERTIFY that the patient has been unable to work from the first day of absence to the indicated return-to-work date OR is still unable to return to work.

Please note: Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b) on this form.

Signature of Health Care Provider:	Date:

SF 4560-G (2-2023)
Supersedes (11-2019)

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FMLA/CFRA – Part A: Medical Information

(To be completed by medical provider)

Limit your response to the medical condition(s) for which the employee is seeking FMLA/CFRA leave. Your answers should be your best estimate based upon your medical knowledge, experience, and examination of the patient. After completing Part A, complete Part B to provide information about the amount of leave needed. Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. §1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

Approximate date the condition started or will start: (mm/dd/yyyy)

Best estimate of how long the condition lasted or will last:

Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B

☐ Inpatient Care:	The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____
☐ Incapacity plus Treatment:	Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for more than three consecutive, full calendar days from _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy). The patient (☐ was / ☐ will be) seen on the following date(s): _____ The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider (e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment)
☐ Pregnancy:	The condition is pregnancy. Expected delivery date: (mm/dd/yyyy):
☐ Chronic Conditions:	Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.
☐ Permanent or Long Term Conditions:	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).
☐ Conditions requiring Multiple Treatments:	Due to the condition, it is medically necessary for the patient to receive multiple treatments.
☐ None of the above:	If none of the above condition(s) were checked, no additional information is needed. Please sign and date the form.

If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. (e.g., use of nebulizer, dialysis): _____
_____
_____
_____

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FMLA/CFRA – Part B: Amount of Leave Needed - *To be completed by medical provider*

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.

Provide your best estimate of the beginning date _____ (mm/dd/yyyy) and end date _____ (mm/dd/yyyy) for the period of incapacity

Due to the condition, it (☐ was / ☐ is / ☐ will be) medically necessary for the employee 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 _____ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ (☐ hours / ☐ days) per episode.

Due to the condition, it is medically necessary for the employee to work a reduced schedule.

Provide your best estimate of the reduced schedule the employee is able to work. From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy) the employee is able to work: (e.g., 5 hours/day, up to 25 hours a week

Due to the condition, the patient (☐ had / ☐ will have) planned medical treatment(s) (scheduled medical visits) (e.g. psychotherapy, prenatal appointments) on the following date(s):

Due to the condition, the patient (☐ was / ☐ will be) referred to other health care provider(s) for evaluation or treatment(s).

State the nature of such treatments: (e.g. cardiologist, physical therapy)

Provide your best estimate of the beginning date _____ (mm/dd/yyyy) and end date _____ (mm/dd/yyyy) for the treatment(s).

Provide your best estimate of the duration of the treatment(s), including any period(s) of recovery (e.g. 3 days/week)

FMLA/CFRA – Part C: Essential Job Functions - *To be completed by medical provider*

If provided, the information in Section I question #4 may be used to answer this question. If the employer fails to provide a statement of the employee's essential functions or a job description, answer these questions based upon the employee's own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be not able to perform the essential job functions of the position during the absence for treatment(s)

Due to the condition, the employee (☐ was not able / ☐ is not able / ☐ will not be able) to perform one or more of the essential job function(s). Identify at least one essential job function the employee is not able to perform:

_____
_____

Attending Provider Information - *To be completed by medical provider*

Health Care Provider's name and credentials: (Print)			
Health Care Provider's business address:			
Phone:	Fax:	Email:	
Signature of Health Care Provider:			Date: