TRISTAR

# CERTIFICATION OF HEALTH CARE PROVIDER – NJ

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|---|---|---|---|
| Employee Name: | | | Patient's name: (if different from employee) |
| Street Address: | | | |
| City: | State: | Zip: | Telephone: |
| Employer Name: | Last Day Worked: | | First Day Missed: |

**Release:** I authorize TRISTAR, my employer's leave administrator, to contact my Health Care Provider, and I authorize my Health Care Provider to communicate with TRISTAR, for purposes of clarification and authenticity of this medical certification.
**Signature of Employee or Patient**: _____**Date:** _____

**COMPLETE THE FOLLOWING STEPS:**
STEP 1: Complete all of the information above. Sign the release.
STEP 2: Complete the upper portion of page 2.
STEP 3: Complete Item 6 on page 2 if for Family Leave. (This portion of the form is to be completed for your Health Care Provider only, NOT TRISTAR.)
STEP 4: Give all pages (1 & 2) to your Health Care Provider and instruct them to complete. After your Health Care Provider has completed both pages 1 & 2 and signed the bottom of page 2,

- **fax the form to TRISTAR at 562/495-6687**
- **email the form to ICSFax@tristargroup.net**
- **mail the form to TRISTAR, 2835 Temple Avenue, Signal Hill, CA 90755**

TRISTAR only needs one copy of this form, so please choose one method of delivery only.

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** *Complete both page 1 & 2 and return to your patient or to TRISTAR directly as instructed above.*

1. **Patient's Diagnosis:** _____

2. **Dates and Duration – for consecutive time frame only**

   a. Approximate date the condition commenced: Start: _____

   b. **Duration** of the condition: Start: _____ End: _____

3. **Regimen of treatment to be prescribed**

   a. Number of visits: _____

   b. General nature of visits: _____

   c. Duration of treatment: Start: _____ End: _____

   d. Referral to other provider of health services? ☐ YES ☐ NO

   e. Is it medically necessary for the employee to be off work on an intermittent basis or to work less than the employee's normal schedule of hours per day or days per week? ☐ YES ☐ NO

   f. Schedule of visits or treatment (e.g.; hours missed per day, ½ days per week, 1-2 day intervals, per week or per month):

   _____

      i. By Physician or Practitioner ☐ YES ☐ NO

      ii. By another provider of health services, if referred by Physician or Practitioner ☐ YES ☐ NO

**4. Employee's Own Serious Health Condition**

   a. Is inpatient hospitalization of the employee required? ☐ YES ☐ NO

   b. Is employee able to perform work of any kind? ☐ YES ☐ NO

   c. Is employee able to perform the functions of employee's position? (Answer after reviewing statement from employer of essential functions of employee's position, or, if none provided, after discussing with employee.) ☐ YES ☐ NO

Employee Name: _____ Employer: _____

**5. Family Care**

a. Is inpatient hospitalization of the family member (patient) required?
☐ YES ☐ NO

b. Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?
☐YES ☐ NO

c. After review of the employee's signed statement (See Employee's Statement below), is the employee's presence necessary or would it be beneficial for the care of the patient? (This may include psychological comfort.)
☐ YES ☐ NO

d. Estimate the period of time care is needed or the employee's presence would be beneficial:
Start: _____ End: _____

**6. Employee's Statement (Family Care Only)**

When Family Leave is needed to care for a seriously-ill family member, the employee shall state the care he or she will provide and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced leave schedule:
Estimate of the time care will be provided: Start: _____ End: _____

Explanation of care to be provided:

_____

_____

_____

_____

_____

Will care be provided on an intermittent or reduced leave schedule? ☐ YES ☐ NO

If yes, please provide the estimated schedule: (eg; hours missed per day, ½ days per week, 1-2 day intervals, per week or per month):

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_____

_____

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The Genetic Information Non-Discrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. Genetic information as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Name of Health Care Provider: _____

Address of Health Care Provider: _____

Office Phone: _____Office Fax: _____

Type of Practice: _____

Signature of Health Care Provider: _____Date: _____