NEW YORK CITY HOUSING AUTHORITY
HUMAN RESOURCES DEPARTMENT

HEALTH CARE CERTIFICATION

TO BE COMPLETED BY EMPLOYEE REQUESTING ANTICIPATED LEAVE

EMPLOYEE'S NAME	TITLE	ID #
WORK LOCATION		
HOME ADDRESS		
HOME TELEPHONE #	FIRST DAY OF ABSENCE	LAST DAY OF ABSENCE *(Tentative)*
EMPLOYEE'S SIGNATURE		DATE

Optional: I hereby authorize my treating physician to provide and/or discuss the information below with the New York City Housing Authority, Department of Human Resources. I understand that this information will be used to help make the determination regarding my request for anticipated leave.

Employee's Signature ____

TO BE COMPLETED BY TREATING PHYSICIAN

1. DOES THE EMPLOYEE HAVE A SERIOUS HEALTH CONDITION THAT REQUIRES: INPATIENT CARE; ABSENCE FROM WORK FOR CONTINUING TREATMENT UNDER THE SUPERVISION OF A HEALTH CARE PROVIDER; OR, INCAPACITY WHICH IS PERMANENT OR LONG TERM FOR WHICH TREATMENT MAY NOT BE EFFECTIVE? IF YES, DESCRIBE THE MEDICAL FACTS THAT SUPPORT YOUR ANSWER.		
2. WHEN DID THE EMPLOYEE'S CURRENT HEALTH CONDITION BEGIN?		
3. HOW LONG DO YOU EXPECT THE EMPLOYEE'S CONDITION TO CONTINUE?		
4. HOW LONG DO YOU EXPECT THE EMPLOYEE'S INABILITY TO WORK TO CONTINUE?		
5. ON WHAT DATE DO YOU ANTICIPATE THE EMPLOYEE WILL BE ABLE TO RETURN TO WORK?		
PHYSICIAN'S SIGNATURE	DATE	TYPE OF PRACTICE
ADDRESS		TELEPHONE #

NYCHA 015.216 (1/06)