THE KAHALA
HOTEL & RESORT
Honolulu, Hawaii

CERTIFICATION OF ILLNESS OR INJURY
(Revised June 2013)

Name of Employee _____ Dept. _____

First day unable to work _____ End Date of Illness/Injury: _____

I was absent and unable to work due to an **accident / illness**.

I certify that this illness/injury was caused by:	YES	NO
a) an industrial accident while employed at The Kahala Hotel & Resort.	___	___
b) an industrial accident while employed at another employer.	___	___

c) Reason/Other:_____

My signature also authorizes my physician to answer any inquiries regarding information on this form.

Employee's Signature:_____ Date:_____

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********Department Head to Complete********

Note time lost and any days off immediately before or after the sick day(s)

Date/Day	Sick/Off	Hours

Total Sick Hours:_____

Manager's Name:_____ Manager's Signature:_____ Date: _____

HR:_____Date:_____ Payroll:_____Date:_____

TO: All Medical Health Care Providers

I hereby authorize the disclosure and use of my protected health information (PHI) as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by the Health Insurance Portability and Accountability Act's (HIPAA) privacy regulations.

A. Information and/or Records Covered by this Authorization: This Authorization pertains to any information, records and/or tests results that relate to my request for sick leave for _____(specify illness or injury for which leave is being requested), beginning on _____(date).

B. Purpose for Disclosing PHI: The disclosure of my PHI is for the purposes of: verifying my illness/injury and any treatment(s) that I may have received; identifying applicable leaves; processing leave requests; fulfilling reporting requirements under federal and/or state law; verifying the need for reasonable accommodations; and facilitating a return to work.

C. Information to be Released/Disclosed to: Authorization is given for the release/disclosure of medical information, to the following persons: Director of Human Resources or Human Resources Administrative/Benefits Manager.

D. Revocation of Authorization: This Authorization is revocable at any time except to the extent that action has been taken in reliance thereon. It is further understood that this Consent constitutes an express waiver of any rule against disclosure otherwise provided by any confidentiality provision of Federal, State, or other applicable law, including the HIPAA privacy regulations.

E. Duration of Authorization: This Authorization shall remain valid until written revocation is received from _____(Name).

F. Copies: A photocopy or facsimile of this Authorization shall be considered as effective and equally valid as the original.

_____ _____ _____

[PRINT NAME] [EMPLOYEE SIGNATURE] [DATE]

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PHYSICIAN'S CERTIFICATE OF DISABILITY (to be completed by Medical Health Care Providers)

I certify that _____ has been **under my professional care.**

Date of first visit for this illness or injury _____If applicable, date(s) of follow-up visit(s)_____

Able to return to regular assigned duties on_____ Diagnosis_____

Was the disability caused by his/her employment: Yes:_____ No:_____

PRINT NAME _____ SIGNATURE: _____ DATE:_____

ADDRESS:_____ PHONE: _____

My Patient Can be returned to:

□ **Full Duty: Effective:** _____

□ **Limited Duty:** (If limited duty, please fill out portion below). **Start Date** _____**End Date**_____

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BASE ON AN 8-HOUR DAY, EMPLOYEE CAN:

❑Stand / Walk: ____ hours at a time ____ total hours ❑ No Restrictions

❑ Kneel: ❑ Not at all ❑ Occasionally ❑ Frequently ❑ No Restrictions

❑Sit: ____ hours at a time ____ total hours ❑No Restrictions

❑Drive: ____ hours at a time ____ total hours ❑No Restrictions

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LIFT/CARRY: (Occasionally = 1/3 workday. Frequently = up to 2/3 workday)

❑ 0-10 lbs. ❑ Not at all ❑Occasionally ❑Frequently ❑No Restrictions

❑ 11-25 lbs. ❑Not at all ❑Occasionally ❑Frequently ❑ No Restrictions

❑ 26-40 lbs. ❑ Not at all ❑Occasionally ❑Frequently ❑ No Restrictions

EMPLOYEE IS ABLE TO

❑ Bend: ❑ Not at all ❑ Occasionally ❑ Frequently ❑ No Restrictions

❑ Squat: ❑ Not at all ❑ Occasionally ❑ Frequently ❑ No Restrictions

❑ Climb: ❑ Not at all ❑ Occasionally ❑ Frequently ❑ No Restrictions

❑ Reach above shoulders:

❑ Not at all ❑ Occasionally ❑ Frequently ❑ No Restrictions

❑ Perform Repetitive Hand Motions:

❑ Not at all ❑ Occasionally ❑ Frequently ❑ No Restrictions

Assistive Devices? (i.e. cast, brace crutches_____

Other therapy required: Frequency_____