Medical Certification of Need for Home or Hospital Instruction

Student Name: Date of Birth:
Grade: School/LEA:

The treating practitioner for the diagnosis related to absences should complete this form. ***It MUST be completed by a licensed physician, licensed nurse practitioner, licensed clinical psychologist, licensed mental health counselor or therapist, or physician's assistant, and cannot be completed by any other provider or the parent/guardian.***

Provider Name:
Provider Title:
Provider License Number:
Provider Email Address:
Hospital/Practice Name:
Hospital/Practice Address:
Hospital Practice Phone Number:

1. Please indicate each of the student's relevant diagnoses, and how the student's health condition(s) has caused or is anticipated to cause the student to be unable to attend in-school instruction, on a continuous, partial, or intermittent basis at the student's school of enrollment or attendance for 10 or more consecutive or cumulative school days during a school year:

2. How will the health condition impact the student's ability to regularly attend school (including whether the student's health condition is anticipated to cause continuous, partial, or intermittent absence from school)?

3. Please confirm whether you are recommending that the student receive home or hospital instruction and why:

4. Recommended start date for home or hospital instruction:

5. When will the student be confined to home or hospital (including frequency and duration of expected absences from school and need for home/hospital instruction)?

6. Describe the student's treatment plan (including frequency and duration) and expected return date to the regular educational environment.

7. Describe how the student's health condition will affect their ability to participate in home/hospital instruction (including any limitations that the health condition may cause).

8. Is there is a maximum number of direct instructional hours that the student may receive per week based on the student's health condition? If so, what is the maximum?

9. Describe any supports or accommodations that the school could implement to enable the student to attend school.

10. List all prescribed medication(s) the student is taking, the side effects of each, and the impact of the medication(s) on the student's ability to access educational benefit in the school setting.

<u>Physician's Certification</u>: I hereby certify the following:

- **This student is under my care and treatment for the aforementioned condition(s).**
- **The student requires home or hospital instruction and is unable to attend school, on a continuous, partial, or intermittent basis, for 10 or more consecutive or cumulative school days during a school year as a result of their health condition(s).**
- **My recommendation has been made on the medical needs of the patient and not parent preferences.**
- **Any treatment plan that may result in impacts to school attendance is medically necessary.**
- **I understand that this certification is for 60 days or the duration estimated in the medical certification of need, whichever is less; and that I will need to recertify the need for continued home or hospital instruction if the need extends beyond 60 days.**

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(Print) Physician's Name	Physician's Signature	Date