Certification of Health Care Provider

To be completed by the district:

The Family Medical Leave Act (FMLA) provides that a district may require an employee seeking FMLA leave protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Employees may not be asked to provide more information than allowed under the FMLA regulations. The district will maintain records and documents relating to medical certification, recertifications, or medical histories of employee's family members, created for FMLA purposes, as confidential medical records in separate files from personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

District contact person: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions _____

_____

Check if job description is attached: ☐

To be completed by the employee:

Complete the information below before giving this form to your family member or his/her medical provider. The return of this form is required to obtain or retain the benefit for FMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request.

Return this completed form on _____ (must be at least 15 days after employee is notified of this requirement).

Employee's name: _____
First Middle Last

To be completed by health care provider:

Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be the best estimate based upon your medical knowledge, experience and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown" or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Extra space is provided, should you need it. Please be sure to sign the form on the last page.

Providers's name and business address: _____

_____

Type of practice/Medical specialty: _____

Telephone: (_____) _____ Fax:(_____) _____

Medical Facts

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Was the patient admitted for an overnight stay in a hospital, hospice or residential medical care facility?

   ☐ Yes ☐ No If yes, dates of admission: _____

   Dates(s) you treated the patient for condition _____

   Was medication, other than over-the-counter medication, prescribed? ☐ Yes ☐ No

   Will the patient need to have treatment visits at least twice per year due to the condition?
   ☐ Yes ☐ No

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   ☐ Yes ☐ No
   If yes, state the nature of such treatments and expected duration of treatment:

   _____

   _____

   _____

2. Is the medical condition pregnancy? ☐ Yes ☐ No

   If yes, expected delivery date: _____

3. Use the information provided by the district in the "To be completed by the district" section to answer this question. If the district fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   Is the employee unable to perform any of his/her job functions due to the condition?
   ☐ Yes ☐ No If yes, identify the job functions the employee is unable to perform:

   _____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis or any regimen of continuing treatment such as the use of specialized equipment):

   _____

   _____

   _____

Amount of leave needed

1. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ☐ Yes ☐ No

   If yes, estimate the beginning and ending dates for the period of incapacity: _____

   _____

2. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ☐ Yes ☐ No

   If yes, are the treatments or the reduced number of hours of work medically necessary?
   ☐ Yes ☐ No

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

   Estimate the part-time or reduced work schedule the employee needs, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

3. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☐ Yes ☐ No

   Is it medically necessary for the employee to be absent from work during the flare-ups?

   ☐ Yes ☐ No If yes, explain: _____

   _____

Based upon the employee's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the employee may have over the next six months (e.g., one episode every three months lasting one to two days):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or _____ day(s) per episode

Additional Information – Identify the question number with your additional answer:

_____

_____

_____

_____

_____

_____

Signature of Health Care Provider Date