

(SCHOOL DISTRICT/INTERMEDIATE SCHOOL DISTRICT)
CERTIFICATION OF HEALTH CARE PROVIDER

Family & Medical Leave Act (FMLA)

1. EMPLOYEE' NAME: _____
2. Patient's Name (if different from employee): _____
3. The attached sheet describes what is meant by a "serious health condition" under the Family & Medical Leave Act. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category.

(1)____(2)____(3)____(4)____(5)____(6)____, or None of the above _____
4. Describe the medical facts which support your certification, including a brief statements as to how the medical facts meet the criteria of one of these categories:
5. A. State the approximate date the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present incapacity if different):

B. Will it be necessary for the employee to work intermittently or to work on a less than full schedule as a result of the condition (including for treatment described in Item 6 below)? _____

If yes, give the probable duration:

C. If the condition is a chronic condition (condition #4) or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity:
6. A. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments: _____

If the patient will be absent from work or other daily activities because of treatment on an intermittent or part-time basis, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

B. If any of these treatments will be provided by another provider of health services (e.g., physical therapist), please state the nature of the treatments:

C. If a regiment of continuing treatment by the patient is required under your supervision provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

7. A. If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind? _____
- B. If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job based on the position description listing essential job functions? If yes, please list the essential functions the employee is unable to perform:
- C. If neither (A.) nor (B.) applies, is it necessary for the employee to be absent from work for treatment? _____
8. A. If leave is required to care for an employee's family member with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation? _____
- B. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? _____
- C. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need:

 (Signature of Health Care Provider)

 (Type of Practice)

 (Address)

 (Telephone Number)

 (Fax Number)

 (Date)

Please return this document to:

(School District/Intermediate School District)
 Attn: Business Office
 (Street Address)
 (City, State, Zip Code)

Questions should be directed to the (Designated Person) at (Area Code) (Phone Number).

**THIS SECTION IS TO BE COMPLETED BY THE EMPLOYEE
NEEDING FAMILY LEAVE TO CARE FOR A FAMILY MEMBER:**

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

(Employee Signature)

(Date)

Please return this document to:

(SCHOOL DISTRICT/INTERMEDIATE SCHOOL DISTRICT)
ATTN: BUSINESS OFFICE
(STREET ADDRESS)
(CITY, STATE, ZIP CODE)

DEFINITIONS OF SERIOUS HEALTH CONDITIONS

A “Serious Health Condition” means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. HOSPITAL CARE

Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity, or subsequent treatment in connection with or consequent to such inpatient care.

2. ABSENCE PLUS TREATMENT

A period of incapacity of more than three (3) consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition) that also involves:

- Treatment two (2) or more times by a health care provider, by a nurse or physician’s assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider, or
- Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.

3. PREGNANCY

Any period of incapacity due to pregnancy, or for prenatal care.

4. CHRONIC CONDITIONS REQUIRING TREATMENTS

A chronic condition which:

- (a) requires periodic visits for treatment by a health care provider, or by a nurse or physician’s assistant under direct supervision of a health care provider;
- (b) continues over an extended period of time (including recurring episodes of a single underlying condition); and
- (c) may cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

5. PERMANENT/LONG-TERM CONDITIONS REQUIRING SUPERVISION

A period of incapacity which is permanent or long-term due to the condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer’s, a severe stroke, or the terminal stages of a disease.

6. MULTIPLE TREATMENTS (NONCHRONIC CONDITIONS)

Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three (3) consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).