SHAWNEE MISSION PUBLIC SCHOOLS
Benefits Office
8200 W. 71st St.
Shawnee Mission, KS 66204
913-993-6495
913-993-6283 fax

Certification of Health Care Provider for Family Member's Serious Health Condition (Family and Medical Leave Act)

SECTION I: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section I before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: _____

Name of family member for whom you will provide care:_____

Describe care you will provide to your family member and estimate leave needed to provide care:

Employee Signature_____ Date_____

SECTION II: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. 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 your 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 patient needs leave. Page 3 provides space for additional information, should you need it. **Please be sure to sign the form on the on the last page.**

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Provider's name and business address:_____

Type of practice / Medical specialty: _____

Telephone: (_____)_____Fax:(_____)_____

PART A: 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? ___No ___Yes. If so, dates of admission:
_____

Date(s) you treated the patient for condition: _____

Was medication, other than over-the-counter medication, prescribed? ___No __Yes.

Will the patient need to have treatment visits at least twice per year due to the condition? ___No ____ Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ____No _____Yes.

If so, state the nature of such treatments and expected duration of treatment:_____

_____

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

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

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No ___Yes. Estimate the beginning and ending dates for the period of incapacity:
_____

During this time, will the patient need care? __ No __ Yes. Explain the care needed by the patient and why such care is medically necessary:

5. Will the patient require follow-up treatments, including any time for recovery? ___No ___Yes.

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

Explain the care needed by the patient, and why such care is medically necessary:

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?

__ No __ Yes.

Estimate the hours the patient needs care on an intermittent basis, if any: _____ hour(s) per day; _____ days per week from _____ through _____

Explain the care needed by the patient, and why such care is medically necessary:

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ____No ____Yes.

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

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

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

Does the patient need care during these flare-ups? ____ No ____ Yes.

Explain the care needed by the patient, and why such care is medically necessary:

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Signature of Health Care Provider : _____ **Date:** _____