Certification of Health Care Provider for Employee's Serious Health Condition (FMLA)

SALT LAKE CITY SCHOOL DISTRICT
Your Best Choice

Section I: EMPLOYEE INFORMATION (Please print)

Employee#

First Name | Middle Name | Last Name

Employer Name: Salt Lake City School District (SLCSD)
Contact: Loretta Campbell
Phone Number: 801-578-8371

Employee's Job Title

Regular Work Schedule

Employee's Essential Job Functions:

Check if job description is attached: ☐ No ☐ Yes

Form is due back to employer by:_____

SECTION II: INSTRUCTIONS TO THE EMPLOYEE

Please give this form to your 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 due to your own 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. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

SECTION III: FOR COMPLETION BY THE HEALTH PROVIDER

Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. 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 employee is seeking leave. Please be sure to sign the form on the last page.

Provider's Name and Business Address **(Please print)**

Type of Practice/Medical Specialty

Telephone | Fax

440 East 100 South, Salt Lake City, Utah 84111 | www.slcschools.org | Phone: 801.578.8340 | Fax: 801.578.8598

PART A: MEDICAL FACTS

1. Approximate date condition commenced:_____Probable duration of condition:_____

Mark below as applicable:

Was the patient admitted for an overnight stay in the hospital, hospice, or residential medical care facility? Yes No
If so, dates of admission: _____

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

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

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

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

_____

2. Is the medical condition pregnancy? Yes No If so, expected delivery date: _____

3. Use the information provided by the employer in section I to answer the question. If the employer 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 so, 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):

_____

_____

_____

_____

_____

_____

_____

_____

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PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time, including any time for treatment and recovery? Yes No

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

6. 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 so, 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_____

7. 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 so, 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 patient may have over the next 6 months (e.g. one episode every three months lasting one to two days):

Frequency _____times per _____week(s) _____ month(s)

Duration _____hours or _____days(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER:

_____

_____

_____

_____

_____

_____

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Signature of Health Care Provider

Date

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