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

SALT LAKE CITY SCHOOL DISTRICT
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INSTRUCTIONS TO THE EMPLOYEE

Please complete this section 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. 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).

Your name: **(please print)**

EIN#

Name of family member for whom you will provide care:

If family member is your son or daughter, date of birth:

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

Employee Signature: **Date:**

INSTRUCTIONS TO THE HEALTH CARE PROVIDER

The employee listed above has requested leave under FMLA to care for your patient. Answer, fully and completely, allapplicable 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 employee is seeking leave. Page 3 provides space for additional information, should you need it. 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:_____

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Part A: MEDICAL FACTS

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

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

☐ No ☐ Yes If yes, 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 employee seeks leave (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 If yes, explain the care needed by the patient and why such care is medically necessary:_____

_____

_____

_____

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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 **Intermittent** or **reduced schedule** basis, including any time for recovery?

☐ No ☐ Yes

Estimate the hours the patient needs care on 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. one episode every three months lasting one to two days):

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

Duration _____hours or _____days(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:

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Signature of Health Care Provider Date

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