

**CONFIDENTIAL MEDICAL INFORMATION TO BE FILED SEPARATE FROM PERSONNEL FILE.**

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



**Quincy School District**  
119 J St SW  
Quincy, WA 98848  
Fax: 509-787-4336  
[qsdleave@qsd.wednet.edu](mailto:qsdleave@qsd.wednet.edu)

**SECTION I: EMPLOYER**

Employers must generally maintain records and documents relating to medical certifications, recertification, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

**Employer name: Quincy School District, 119 J ST SW Quincy, WA 98848**

**COMPLETED FORM MAY BE MAILED, EMAILED OR FAXED. FAX NUMBER IS: 509-787-4336**

**Employer contact information:**

Robin Mauro, 787-4571, [qsdleave@qsd.wednet.edu](mailto:qsdleave@qsd.wednet.edu)

**SECTION II: For Completion by the EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** 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).

Employee's name: \_\_\_\_\_  
Please Print Clearly      First, Middle, Last      School/Department

Employee's job title: \_\_\_\_\_ Regular work schedule: \_\_\_\_\_

Employee's essential job functions: \_\_\_\_\_

### SECTION III: For Completion by the HEALTH CARE PROVIDER

**INSTRUCTIONS to the HEALTH CARE 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. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee’s family members, 29 C.F.R. § 1635.3(b). **Please be sure to sign the form on the last page.**

Your patient and/or our employee name: \_\_\_\_\_

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: \_\_\_\_\_

**Mark below as applicable:**

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. Use the information provided by the employee in Section II to answer this question 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: \_\_\_ No \_\_\_ Yes

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):

\_\_\_\_\_

**PART B: AMOUNT OF LEAVE NEEDED:**

5. 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? \_\_\_\_\_No \_\_\_\_\_Yes

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? \_\_\_\_\_No \_\_\_\_\_Yes

If so, are the treatments or the reduced number of hours of work medically necessary? \_\_\_\_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:

\_\_\_\_\_

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? \_\_\_\_\_No \_\_\_\_\_Yes

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

\_\_\_\_No\_\_\_\_Yes. If so, explain:

\_\_\_\_\_

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

\_\_\_\_\_  
**Signature of Health Care Provider**

\_\_\_\_\_  
**Date**

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.