

PIERCE COUNTY SCHOOLS
FMLA CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS
HEALTH CONDITION

SECTION I: For Completion by the EMPLOYER

Employer name: **Pierce County Board of Education**

Contact: **Payroll Department**

Employee's job title _____

Regular work schedule _____

Employee's essential job functions_____

Check if job description is attached _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving 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. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. **Please return this form within 15 calendar days, but no later than**

Your name _____

First Middle Last

ADOPTED: 9-14-09

REVISED:

PIERCE COUNTY BOARD OF EDUCATION

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. Please be sure to sign the form on the last page.

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 _____

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

_____ No _____ Yes

Was medication, other than over-the-counter medication, prescribed? _____ 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 _____

ADOPTED: 9-14-09

REVISED:

PIERCE COUNTY BOARD OF EDUCATION

3. Use the information provided by the employer in Section I to answer this 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? ____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 on a reduced schedule because of the employee's medical condition? ____No ____ Yes

If so, are the treatment 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 _____

Will the employee need part-time or a reduced work schedule? ____No ____ Yes

____hour(s) per day; ____days per week from ____through ____

ADOPTED: 9-14-09

REVISED:

PIERCE COUNTY BOARD OF EDUCATION

FMLA CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE'S HEALTH CONDITION

PAGE: 4 of 4

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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER

Signature of Health Care Provider

Date

ADOPTED: 9-14-09

REVISED:

PIERCE COUNTY BOARD OF EDUCATION