CYPRESS FAIRBANKS
INDEPENDENT SCHOOL DISTRICT

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

SECTION I: For Completion by the EMPLOYER

Employer name and contact: Cypress Fairbanks ISD **281-897-4396**

Employee Name: _____

Employee's job title: _____

Regular work schedule: _____

Employee's essential job functions: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: To support your request for leave you are required to submit a timely, complete, and sufficient medical certification to support this request for leave due to your own serious health condition. It is your responsibility to have this form completed and signed by your health care provider, and to return it to the Human Resources department by the date below. If you have any questions, please call 281-897-4396.

Your failure to provide a complete and sufficient medical certification by the date below may result in denial of your leave request.

COMPLETED FORM MUST BE RECEIVED IN HR BY: _____

Fax: 281-897-3861
Email: Annette.jimenez@cfisd.net
Mail: 11440 Matzke Road, Cypress, TX 77429

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave for his or her own health condition. Please answer all applicable parts of this certification fully and completely. 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 leave coverage. Please limit your responses to the condition for which the employee is seeking leave.

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

1. Provider's name: _____

Provider's business address: _____
Name of Practice / Organization

_____
Street # Suite#

_____
City State Zip

Type of Practice / Medical Specialty: _____

Telephone: (_____) _____ Fax: (_____) _____

Employee Name: _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____/_____/_____
2. Probable duration of condition:_____
3. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ___ No ___ Yes If so, dates of admission:
   _____
4. Date(s) you treated the patient for condition: _____
5. Will the patient need to have treatment visits at least twice per year due to the condition?

   ___ No ___ Yes

6. Was medication, other than over-the-counter medication, prescribed? ___ No ___ Yes
7. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

   ___ No ___ Yes

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

   _____
8. Is the medical condition pregnancy? ____ No ____ Yes

   If so, expected delivery date: _____/_____/_____
9. 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: _____

   _____

   _____
10. 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

11. 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:

    From: _____/_____/_____ To: _____/_____/_____
12. 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?

Employee Name: _____
___ No ___ Yes

13. 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:

____ hours per day____ days per week From: ____/____/_____ Through: ____/____/_____

14. 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: _____ weeks(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**:** _____/_____/_____

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.