HUMAN RESOURCES DEPARTMENT

651-351-8340
www.stillwaterschools.org
1875 South Greeley Street
Stillwater, MN 55082

Medical Certification Statement

1. Employee's Name _____ 2. Patient's Name (*If different)* _____

3. Nature of Condition: Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of a **"serious health condition"** (*page 3 describes serious health condition)* _____

_____

_____

4a. Date condition commenced _____4b. Probable duration of condition (leave end date)_____

4c. Will it be necessary for the employee to take work only **intermittently or to work on less than a full schedule** as a result of the conditions (including for treatment described in question 5 below)

☐ Yes ☐ No

If yes, give the probable duration: _____

_____

5a. If additional **treatments** will be required for the condition, provide an estimate of the probable number of such treatments: _____

_____

5b. If any of these treatments will be provided by **another provider of health services** (e.g., physical therapist), please state the nature of treatments: _____

_____

5c. If **a regimen of continuing treatment** by the patient is required under your supervision, provide a general description of such regimen: _____

_____

5d. Was medication, other than over-the-counter medication, prescribed? ☐ Yes ☐ No

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Employee

6a. If medical leave is required for the employee's absence from work because of the **employee's own condition** (including absences due to pregnancy or a chronic condition), is the employee **unable to perform work of any kind**?
☐ Yes ☐ No ☐ Does not apply

6b. If able to perform some work, is the employee **unable to perform any one or more of the essential functions of the employee's job** (Answer after reviewing statement from employer of essential functions of employee's position, or if none provided, after discussion with the employee.)
☐ Yes ☐ No ☐ Does not apply

6c. If neither a. nor b. applies, is it necessary for the employee to be **absent form work for treatment**?
☐ Yes ☐ No

Family Member

7a. If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation?
☐ Yes ☐ No

7b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery?
☐ Yes ☐ No

7c. If the patient will need care only intermittently or on a part-time basis please indicate the probable duration of this need: _____

_____

_____
Signature of Health Care Provider

_____
Date

_____
Type of Practice

( )_____
Telephone Number

_____
Address

( )_____
Fax Number

*Note: Due to the confidential nature of this information, please return the completed form marked "Strictly Confidential" to:

Human Resources/ Stillwater Area Public Schools/1875 S. Greeley Street/ Stillwater, MN 55082/ Fax: (651) 351-8330

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A **"Serious Health Condition"** means an illness, injury impairment, or physical or mental condition that involves one of the following:

1. Hospital Care

   Inpatient care (*i.e.*, an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity[2] or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

   (a) A period of incapacity[2] of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity[2] relating to the same condition), that also involves:

   (1) **Treatment**[3] **two or more times** by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (*e.g.*, physical therapist) under orders of, or on referral by, a health care provider; or

   (2) **Treatment** by a health care provider on **at least one occasion** which results in a **regimen of continuing treatment**[4] under the supervision of the health care provider.

3. Pregnancy

   Any period of incapacity due to **pregnancy**, or for **prenatal care**.

4. Chronic Conditions Requiring Treatments

   A **chronic condition** which:

   (1) Requires **periodic visits** for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;

   (2) Continues over an **extended period of time** (including recurring episodes of a single underlying condition); and

   (3) May cause **episodic** rather than a continuing period of incapacity[2] (*e.g.*, asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-term Conditions Requiring Supervision

   A period of **Incapacity**[2] which is **permanent or long-term** due to a condition for which treatment may not be effective. The employee or family member must be **under the continuing supervision of, but need not be receiving active treatment by, a health care provider**. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. Multiple Treatments (Non-Chronic Conditions)

   Any period of absence to receive **multiple treatments** (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for **restorative surgery** after an accident or other injury, **or** for a condition that **would likely result in a period of Incapacity**[2] **of more than three consecutive calendar days in the absence of medical intervention or treatment**, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), and kidney disease (dialysis).

This optional form may be used by employees to satisfy a mandatory requirement to furnish a medical certification (when requested) from a health care provider, including second or third opinions and recertification (29 CFR 825.306).

Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

[3] Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

[4] A regimen of continuing treatment includes, for example, a course of prescription medication (*e.g.*, an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

Public Burden Statement

We estimate that it will take an average of 20 minutes 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 of information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE; IT GOES TO THE EMPLOYEE.

*U.S. GPO: 2000-461-954/25505