

**THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA
CERTIFICATION OF HEALTH CARE PROVIDER
FOR EMPLOYEE'S SERIOUS HEALTH CONDITION
(FAMILY AND MEDICAL LEAVE ACT)**



Please email documentation to leaves@browardschools.com

INSTRUCTIONS to the EMPLOYEE:

Please complete Questions 1-8 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. 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. 29 C. F. R. §825.313. Your employer must give you at least fifteen (15) calendar days to return this form. 29 C.F.R. § 825.305(b).

1. _____
Employee's Name
2. _____
Employee's Personnel Number
3. _____
Work Location Name
4. _____
Employee's Job Title
5. Employee's Essential Job Functions: _____
6. Employee's Regular Work Schedule: _____
7. Check if Job Description Attached: _____
8. _____
Employee's Signature
- _____ Date

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts listed 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 Two (2) provides space for additional information, should you need it. **Please be sure to sign the form on the last page.**

1. Provider's Name: _____
2. Provider's Business Address: _____
3. _____
Type of Practice/Medical Specialty
4. _____
Telephone Number Fax Number

PART A: MEDICAL FACTS

5. Approximate date condition commenced: _____
Probable duration of condition: _____
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 yes, state the nature of such treatments and **expected duration of treatment:**

6. Is the medical condition pregnancy? ____ No ____ Yes. If yes, expected delivery date: _____
7. Use the information provided by the employee in Section 1 to answer this question. If the employee's essential job functions or job description is not provided, answer these questions based upon the employee's own description of his/her 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: _____
8. 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

9. 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.
10. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of this medical condition? ____ No ____ Yes
If so, are the treatments or the reduced number of hours of work medically necessary? ____ No ____ Yes
11. 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: _____

If you answered yes to Q. 10 or Q. 11, please complete information below:

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups or appointments and the duration of related incapacity that the patient may need (e.g., 1 time every three (3) months lasting 1-2 days):

Frequency: _____ time(s) every (**check one**) ☐ week ☐ month

Duration: _____ hours **OR** _____ consecutive day(s) per episode

Please indicate the estimated range of time in which the employee will need to take of for these flare-ups or appointments (length may not exceed 1 year from start date and must be given in month/day/year.)

Start Date: _____ End Date: _____

12. **ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.** _____

Signature of Health Care Provider

Date