

Highland Park Independent School District

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

SECTION I: For Completion by the EMPLOYER

Employer Name: Highland Park Independent School District

Employer Contact: Melinda Tubb, Personnel Specialist

Telephone: (214) 780-3012 Fax: (214) 780-3099

Employee's Job Title and Regular Work Schedule: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form and any attachments to your health care provider. The Family and Medical Leave Act ("FMLA") permits Highland Park ISD to require that you submit a timely, complete, and sufficient medical certification to support a request for family and medical leave due to your own serious health condition. Your response is required to obtain or retain the benefit of the FMLA's protections. If you do not provide a complete and sufficient medical certification by _____, which is at least 15 days from your receipt of this form, Highland Park ISD will delay or deny the leave, continued leave, or restoration to employment, treat your absence as unexcused, and impose appropriate disciplinary action, up to and including termination of employment.

Employee Name: _____
First Middle Last

SECTION III. For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Please answer all applicable parts fully and completely. Several questions seek a response as to the frequency or duration of a condition or treatment. You should provide the best estimate based on your medical knowledge, experience, and examination of the patient. Please be as specific as possible; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. You should limit your responses to the condition for which the patient seeks family and medical leave. Please do not provide any information about the patient's family medical history or genetic information (and see further instructions on page 4 regarding genetic information). Page 4 provides space for additional information should you require it. **Please sign and date the form on the last page. Highland Park ISD ☐ has ☐ has not provided information about the patient's essential job functions or a job description.**

Name of Health Care Provider: _____

Business Address: _____

Type of Practice / Medical Specialty: _____

Telephone (with area code): _____ Fax: _____

PART A: MEDICAL FACTS

1. Approximate date when the condition commenced: _____

Probable duration of the condition: _____

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Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

____No ____Yes. If so, list the dates of admission:

List the date(s) when you treated the patient for the 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 a pregnancy? ____No ____Yes. If so, list the expected delivery date:

3. **If Highland Park ISD has provided information about the patient's essential job functions or a job description, use that information to answer this question.** If Highland Park ISD has not provided information about the patient's essential job functions or a job description, answer these questions based on the patient's description of his or her job functions.

Is the patient unable to perform any of his or her job functions because of the condition: ____No ____Yes. If so, identify the job functions the patient is unable to perform:

What is the likely duration of the patient's inability to perform his or her job functions? _____

Do you recommend any work restrictions? ____ No ____ Yes. If so, identify the nature of the work restrictions:

How long are the work restrictions described above to remain in effect? _____

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4. Describe other relevant medical facts, if any, related to the condition for which the patient seeks leave (the 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 patient be incapacitated for a single continuous period due to his or 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 patient need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of his or her medical condition? ____No ____Yes

If so, are the treatments or the reduced number of hours of work medically necessary? ____No ____Yes

If so, explain:

Estimate the 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 patient needs, if any:

____ hour(s) per day; ____ day(s) per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the patient from performing his or her job functions? ____No ____Yes

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

If so, explain:

Based on 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 six months (e.g., one episode every three months lasting one to two days):

Frequency: ____ times per ____ week(s) or ____ month(s).

Duration: ____ hours or ____ day(s) per episode.

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INSTRUCTIONS TO HEALTH CARE PROVIDER REGARDING GENETIC INFORMATION

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 collect or provide any genetic information when responding to our request for medical information concerning the employee. "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.

ADDITIONAL INFORMATION: IDENTIFY QUESTION WITH YOUR ADDITIONAL ANSWER

Signature of Health Care Provider

Date

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