Highland Park Independent School District

Certification of Health Care Provider for Family Member'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

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his or 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 to care for a covered family member with a 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. **Please sign and date below.**

Employee Name: _____
First Middle Last

Name of family member to whom you will provide care: _____
First Middle Last

Relationship of family member to you: _____

If the family member is your son or daughter, list his or her date of birth: _____

Estimated leave needed to provide care to family member: _____

Describe the care that you will provide to your family member: _____

_____

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_____

I certify that all statements in this request are true and complete to the best of my knowledge. I further understand that if I make any false or misleading oral or written statement in connection with my request for leave, I will be subject to appropriate disciplinary action, up to and including termination of employment.

_____ _____

Employee Signature **Date**

SECTION III. For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed on Page 1 has requested leave under the FMLA to care for your patient. 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 upon 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 patient's condition for which the employee seeks leave to provide care. Please do not provide any information about the patient's family medical history or genetic information. Page 4 provides space for additional information, should you require it. **Please sign and date the form on the last page.**

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: _____

   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. Describe other relevant medical facts, if any, related to the condition for which the patient needs care from the employee or another person (the medical facts may include symptoms, diagnosis, or any regimen of continuing treatment, such as the use of specialized equipment):

   _____

   _____

   _____

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PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care from the employee (or another person) seeking leave may include assistance with basic medical hygiene, nutritional, safety, or transportation needs, or the provision of physical or psychological care.

4. 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: _____

   During that time, will the patient need care from the employee or another person? _____ No _____ Yes

   If so, explain the care needed by the patient from the employee or another person and why such care is medically necessary:

   _____

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5. Will the patient require follow-up treatment, including any time for recovery? _____No _____Yes

   If so, estimate the treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

   _____

   Will the patient need care from the employee or another person as a result of the follow-up treatment?
   _____ No _____ Yes

   If so, explain the care needed by the patient from the employee or another person and why such care is medically necessary:

   _____

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6. Will the patient require care from the employee or another person on an intermittent or reduced-schedule basis, including any time for recovery? _____No _____Yes

   If so, estimate the hours that the patient needs care from the employee or another person on an intermittent basis, if any:

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

   Explain the care needed by the patient from the employee or another person and why such care is medically necessary:

   _____

   _____

   _____

   _____

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? _____No _____Yes

   If so, 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.

   Will the patient need care from the employee or another person during those flare-ups? _____No _____Yes

   If so, explain the care needed by the patient from the employee or another person and why such care is medically necessary:

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ADDITIONAL INFORMATION: IDENTIFY QUESTION WITH YOUR ADDITIONAL ANSWER

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Signature of Health Care Provider **Date**

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