

GRAND PRAIRIE INDEPENDENT SCHOOL DISTRICT

TEMPORARY DISABILITY LEAVE

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

Submit to: Human Capital Office, Attn: Dr. Karen Gonzalez

karen.gonzalez@gpisd.org

SECTION I - EMPLOYER

Any full-time employee whose position requires educator certification by the State Board for Educator Certification or by the district shall be eligible for temporary disability leave. The maximum length of temporary disability leave shall be 180 calendar days. [See DBB(LOCAL) for temporary disability leave placement and DEC(LEGAL) for return to active duty.]

An employee's notification of need for extended absence due to the employee's own medical condition shall be forwarded to the Superintendent as a request for temporary disability leave. The request must be accompanied by a physician's statement confirming inability to work, state the date requested by the educator for the leave to begin, and state the probable date of return as certified by the physician. The district shall require the employee to use temporary disability leave and paid leave, including any compensatory time, concurrently with FMLA leave.

(1) Employer name: **Grand Prairie Independent School District**

(2) Employee name _____

(3) Employee's job title _____

SECTION II - HEALTH CARE PROVIDER

Please provide your contact information. Your patient has requested temporary disability leave as provided by GPISD. The district TDL policy allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for TDL due to the serious health condition of the employee. For TDL purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves **inpatient care** or **continuing treatment by a health care provider**.

You also may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

Health Care Provider's name: (Print) _____

Health Care Provider's business address: _____

Type of practice / Medical specialty: _____

Telephone: _____ Fax: _____ Email: _____

MEDICAL INFORMATION

Please complete all relevant parts of this section and sign the form.

(1) Estimated date on which the condition started or will start: _____

(2) Provide your **best estimate** of how long the condition lasted or will last: _____

(3) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided.

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☐ **Inpatient Care:** The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____

☐ **Incapacity plus Treatment:** (e.g., outpatient surgery, strep throat)

Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for **more than five** consecutive, full calendar days from: _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy).

The patient (☐ was / ☐ will be) seen on the following date(s): _____

The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider (e.g., prescription medication (other than over the counter) or therapy requiring special equipment).

☐ **Pregnancy:** The condition is pregnancy. List the expected delivery date: _____ (mm/dd/yyyy).

☐ **Chronic Conditions:** (e.g., asthma, migraine headaches) Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Permanent or Long-Term Conditions:** (e.g., Alzheimer's, terminal stages of cancer) Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Conditions Requiring Multiple Treatments:** (e.g., chemotherapy treatments, restorative surgery) Due to the condition, it is medically necessary for the patient to receive multiple treatments.

If necessary, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. (e.g., use of nebulizer, dialysis) _____

AMOUNT OF LEAVE NEEDED

Please complete all that apply

Due to the condition, the patient (☐ had / ☐ will have) **planned medical treatment(s)** (scheduled medical visits) (e.g., psychotherapy, prenatal appointments) on the following date(s): _____

Due to the condition, the patient (☐ was / ☐ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date _____ (mm/dd/yyyy) and end date _____ (mm/dd/yyyy) for the period of incapacity.

Due to the condition, the employee (☐ was not able / ☐ is not able / ☐ will not be able) to perform **one or more** of the essential job function(s). Identify at least one essential job function the employee is not able to perform:

Signature of Health Care Provider: _____ Date: _____ (mm/dd/yyyy)