SHORELINE PUBLIC SCHOOLS
Shoreline Public Schools
Office of Human Resources
ATTN: Aileen Finnigan Leave Specialist
Fax: (206) 393-4218
E-Mail: aileen.finnigan@ssd412.org

Certification of Health Care Provider

☐ Family and Medical Leave Act (FMLA)
☐ Medical Leave of Absence
☐ Family Leave Act (FLA)
☐ Temporary Disability Leave
☐ Pregnancy Disability (WLAD)
☐ Accommodation Documentation

*Certain leaves of absences may run concurrently. Check all that apply.

Section I:

Employer Contact: Human Resources, (206) 393-4329

Employee's Job Title: _____

Regular Work Schedule: _____

Employee's Essential Job Functions: _____

☐ Check if job description is attached.

Section II:

Employee Name: _____

Department/School: _____

I am requesting a leave of absence under one or more of the leaves listed above; therefore, I authorize the release of the information requested below to the Shoreline Public Schools.

. _____ _____

Employee Signature **Date**

Section III: For Completion by the Health Care Provider

Your patient has requested a medical leave of absence. Answer fully and completely, all applicable parts. 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 specific as you can; terms such as "lifetime", "unknown", or "indeterminate" may not be sufficient to determine coverage under requested leave(s). Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, genetic services, or the manifestation of disease or disorder in the employee's family members. Please be sure to sign the form on the last page.

Provider's Name and Business Address:

_____

Type of Practice/Medical Specialty:

_____

Telephone: (_____)_____ Fax: (_____)_____

Part A: Medical Facts

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Mark below as applicable:

   Was the patient admitted for an overnight stay in the hospital, hospice, or residential medical care facility? ☐ No ☐ Yes If yes, date of admission:

   Dates(s) you treated the patient for condition:

   Will the patient need 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 therapy)?

   ☐ No ☐ Yes If yes, state the nature of such treatments and expected duration:

2. Is this medical condition pregnancy? ☐ No ☐ Yes

   If yes, expected delivery date: _____

3. Based on the essential functions listed in Section I and/or the employee job description, is the employee unable to perform any of his/her job functions due to the condition: ☐ No ☐ Yes

   If yes, identify the job functions the employee is unable to perform:

4. 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

5. 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 yes, estimate the beginning and ending dates for the period of incapacity:
   _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ☐ No ☐ Yes
   If yes, are the treatments or the reduced number of hours of work medically necessary?
   ☐ No ☐ Yes
   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

7. 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 yes, 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 6 months (e.g. 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ months(s)

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

Additional Information:

Signature of Health Care Provider **Date**