Shoreline Public Schools
Office of Human Resources
ATTN: Aileen Finnigan Benefit & Leave Specialist
Fax: (206) 393-4218

Care for Family Member

Certification of Health Care Provider

- ☐ Family and Medical Leave Act (FMLA)
- ☐ Family Leave Act (FLA)
- ☐ Pregnancy Disability (WLAD)
- ☐ Medical Leave of Absence
- ☐ Temporary Disability Leave
- ☐ Care for Family Member

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

Section I:

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

Employee's Job Title:

Regular Work Schedule:

Section II: For Completion by the Employee

Employee Name: _____

Department/School: _____

Name of Family Member: _____

Relationship to you: _____

If son or daughter, date of birth _____

Describe care you will provide to Family member, and estimate leave needed to provide care.

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

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts 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 patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Page 3 provides space for additional information, should you need it. 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. Describe other relevant medical facts, if any, related to the condition for which the patient 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 CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety ortransportation needs, or the provision of physical or psychological care:

4. Will the patient 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:

   _____

   During this time, will the patient need care? ☐ No ☐ Yes

   Explain the care needed by the patient and why such care is medically necessary.

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5. Will the patient require follow-up treatments, including any time for recovery? ☐ 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:

   Explain the care needed by the patient and why such care is medically necessary.

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6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?

   ☐ No ☐ Yes

   Estimate the hours the patient needs care on an intermittent basis, if any:

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

   From: _____ Through: _____

   Explain the care needed by the patient 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

   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

   Explain the care needed by the patient and why such care is medically necessary.

Additional Information:

Signature of Health Care Provider **Date**