Independent School District 15
4115 Ambassador Boulevard NW, St. Francis, MN 55070
763-753-7040 • www.isd15.org

Employee FMLA/Leave of Absence

Certificate of Health Care Provider for Employee's Health Condition

Section 1: For completion by ISD 15 Human Resources

Employer Name: Independent School District 15 Contact: Joyce Froh, Phone 763-753-7058, FAX 763-753-4693

Employee Name _____ Employee Job Title _____

Location _____ Regular Work Schedule _____

Section II: Instructions for Employee

Family Medical Leave Act (FMLA) permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. You have 15 calendar days to return this form to ISD 15 Human Resources, Central Services Center.

Section III: For Completion by Health Care Provider

Your patient has requested leave under FMLA. 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 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. Please be sure to sign the form on the last page.

Provider's Name _____

Provider's Business Address _____

Type of practice/medical specialty _____

Phone _____ 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 a hospital, hospice, or residential care facility?

   ☐ No ☐ Yes If Yes, date(s) of admission _____

   Date(s) patient was treated for condition _____
   Will the patient need to have treat visits at least twice per year due to 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 Yes, state the nature of such treatments and expected duration of treatment?

   _____

   _____

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2. Is the medical condition pregnancy? ☐ No ☐ Yes If Yes, expected delivery date _____

3. Use the information provided by ISD 15 in Section 1 to answer this question.
   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.

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4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts which may include symptoms, diagnosis or any regimen of continuing treatment such as the use of specialized equipment). Please attach restrictions, if any.

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PART B: Amount of Leave Needed

5. Will the patient be incapacitated for a single continuous period of time, 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 treatments, appointments, work part-time or work a reduced/flexible 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.

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Estimate the part-time or reduced work schedule the employee needs, if any

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

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7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☐ No ☐ Yes

8. Is it medically necessary for the employee to be absent from work during flare-ups? ☐ No ☐ Yes

   If Yes, explain _____

   Based upon 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) _____

   Duration _____ Hours or _____ Day(s) per episode _____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

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Signature of Health Care Provider _____ Date _____

Employer Name: Independent School District 15
4115 Ambassador Boulevard NW
St. Francis, Minnesota 55070-9368

Contact: Joyce Froh, Phone 763-753-7058, FAX 763-753-4693

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