Independent School District 15
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Family Member FMLA/ Leave of Absence

Certificate of Health Care Provider for Family Member's Health Condition

Section 1: For completion by the employee

Instructions to the Employee: Please complete Section I before giving this form to your family member or his/her medical provider. 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 to care for a covered family member with a 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.

Employee Name _____

Name of family member for whom you will provide care _____

Relationship of family member to you _____

If family member is your son or daughter, date of their birth_____

Describe care you will provide to your family member and estimate leave needed to provide care

_____

_____

_____

Employee signature _____ Date _____

Section II: For Completion by Health Care Provider

Instructions to Health Care Provider: The employee listed above has requested leave under FMLA to care for your patient. 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. 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 _____

Provider's Business Address _____

Type of practice/medical specialty _____

Phone _____ FAX_____

PART A: Medical Facts

1. Approximate date condition commenced_____

   Probable duration of condition_____

   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 _____

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Was medication, other than over-the-counter medication, prescribed? ☐ No ☐ Yes

Will the patient need to have treat visits at least twice per year due to condition? ☐ 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?

_____

_____

2. Is the 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 employee seeks leave (such medical facts which 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 or transportation needs, or the provision of physical or psychological care:

4. 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

   _____

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

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

   _____

   _____

   _____

   _____

   _____

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.

   _____

   _____

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

_____

_____

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

_____ hour(s) per day _____ days per week 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 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) Times per _____ Month(s)

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

Does the patient need care during these flare-ups? ☐ No ☐ Yes

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

_____

_____

Additional Information: Identify question number with your additional answer.

_____

_____

_____

_____

_____

_____

_____

Signature of Health Care Provider _____ Date _____

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