Three Rivers School District

Code: GCBDA/GDBDA-AR(3)(B)
Revised/Reviewed: 7/21/15; 11/17/21
Orig. Code: GCBDA/GDBDA-AR(3)(B)

Certification of Health Care Provider

To be Completed by the Three Rivers School District:

The Family Medical Leave Act (FMLA) provides that a district may require an employee seeking FMLA leave protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Employees may not be asked to provide more information than allowed under the FMLA regulations. The district will maintain records and documents relating to medical certification, recertifications or medical histories of the employee's family members, created for FMLA purposes, as confidential medical records in separate files from personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

District contact person: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

_____

Check if job description is attached: ☐

Return this completed form on _____ (date) (must be at least 15 days after employee is notified of this requirement).

To be Completed by the Employee:

Complete the information below before giving this form to your family member or his/her medical provider. The return of this form is required to obtain or retain the benefit for FMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request.

Employee's name: _____
First Middle Last

Relationship and name of family member for whom employee will provide care: _____
Relationship

_____
First Middle Last

If the family member is your child, please provide his/her date of birth: _____

DELETE

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

_____

_____

_____

_____ _____

Employee signature Date

To be Completed by 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 the 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), C.F.R. § 1635.3(b). Extra space is provided, 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: (___) _____

Email: _____

Medical Facts

1. The approximate date the condition commenced: _____

   The probable duration of the condition: _____

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

   List the dates(s) you treated the patient for their condition: _____

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

   Will the patient need to have treatment visits at least twice per year due to the condition? □ Yes □ No

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g. physical therapist)? □ Yes □ No

   If yes, state the nature of such treatments and expected duration of treatment:

   _____

   _____

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2. Is the medical condition pregnancy? □ Yes □ No

   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 may include symptoms, diagnosis or any regimen of continuing treatment such as the use of specialized equipment):

   _____

   _____

   _____

Amount of Leave Needed

When answering these questions, keep in mind that your patient's need for care from the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

1. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? □ Yes □ No

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

   _____

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

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

2. Will the patient require follow-up treatments, including any time for recovery? □ Yes □ No

   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: _____

   _____

   _____

3. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? □ Yes □ No

   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: _____

   _____

   _____

DELETE

4. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ☐ Yes ☐ No

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 six months (e.g. one episode every three months lasting one to two days):

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

Duration: _____ hours or _____ day(s) per episode

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

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

_____

_____

Additional Information (Identify the question number with your additional answer):

_____

_____

_____

_____

_____

_____ _____

Signature of health care provider Date

DELETE