Certification of Health Care Provider for Family Member's Serious Health Condition
Family and Medical Leave Act

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the **EMPLOYER:** FMLA provides that an employer may require an employee seeking FMLA 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.

Employer name: Douglas County West Community Schools

Employer contact person: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her medical provider. The 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. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. Your employer must give you at least 15 calendar days to return this form to your employer.

Your name: _____
First Middle Last

Name of family member for whom you will provide care: _____
First Middle Last

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____

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

_____

_____

_____

_____

_____ _____
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. 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: _____

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

   Date(s) you treated the patient for condition: _____
   _____
   _____

   Was medication, other than over-the-counter medication, prescribed? ___No ___ Yes.

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

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ___ No ___ Yes. If so, state the nature of such treatments and expected duration of treatment: _____
   _____

2. Is the medical condition pregnancy? ___No___Yes. If so, expected delivery date: _____.

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regiment of continuing treatment such as the use of specialized equipment): _____
   _____

   _____

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Part B: AMOUNT OF CARE NEEDED

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___ No ___ 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 treatment, 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: _____
   _____

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 conditions 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) _____ 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:

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Signature of Health Care Provider **Date**