Alachua County Public Schools

Division of Human Resources

Family Medical Leave Act (FMLA)
Certification of Health Care Provider for *Employee's* Serious Health Condition

SECTION I (To be completed by Employee)

Complete the following questions before giving this form to your health care 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 due to your own serious health condition. Your response is required to obtain or retain the benefit of FMLA protections, 29 U.S.C. §2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in denial of your FMLA request, 29 C.F.R. §825.313. Pursuant to C.F.R. §825.305(b), you have fifteen (15) calendar days from the submission date of your FMLA Application/Designation Notice to return this form to the Personnel Services Department.

Employee's Name:_____ Employee ID#:_____

School/Dept.:_____ Position Title:_____

_____ _____

Signature of Employee *Date*

SECTION II (To be completed by the Health Care Provider)

Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts listed 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 employee is seeking leave. **Be sure to sign Page 2 of this form**.

Health Care Provider Name:_____

Type of Practice/Medical Specialty:_____

Business Address:_____

Telephone Number:_____ FAX Number:_____

PART A: MEDICAL FACTS

1. Approximate date condition commenced _____ Probable duration of condition _____

   Mark below as applicable:

   Was the patient admitted to an overnight stay in a hospital, hospice, or residential medical care facility? ☐Yes ☐No

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

   Was medication, other than over-the-counter medication, prescribed? ☐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:

   _____

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

PART A: MEDICAL FACTS (continued)

3. Based on the job description provided or the employee's own description of his/her job functions, is the employee unable to perform any of his/her job functions due to this condition? ☐Yes ☐No If yes, identify the job functions the employee is unable to perform.

4. Describe the serious medical condition for which the employee seeks leave.

PART B: AMOUNT OF CARE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to the medical condition, including any time for treatment and recovery? ☐Yes ☐No

   Estimate the beginning date _____and ending date _____ for the period of Incapacity.

   If leave estimated date cannot be determined, provide us the date of the next evaluation: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time on a reduced schedule because of the employee's medical condition? ☐Yes ☐No

   If yes, are the treatments or reduced number of hours of work medically necessary? ☐Yes ☐No

   Estimate the treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period.

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

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

   If yes, please 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 incur over the next six (6) months (e.g., episode every three (3) months lasting 1-2 days).

   Frequency: ____ times per ____ week(s) ____months(s) Duration: ____ hours or ____ day(s) per episode

ADDITIONAL INFORMATION (Identify question number with your additional response)

_____ _____

Signature of Health Care Provider *Date*