Alachua County Public Schools

Division of Human Resources

Family Medical Leave Act (FMLA)
Certification of Health Care Provider for *Family Member'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 a family member's 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:_____

Name of Family Member for Who You will Provide Care:_____

Relationship of Family Member to You: ☐Spouse ☐Child ☐Parent

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

_____

_____ _____

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

PART A: MEDICAL FACTS (Continued)

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:_____

3. Describe the serious medical condition for which the employee seeks leave to care for an immediate family member

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. If the answer to any of questions 4-7 is yes, explain the care needed by the patient and why such care is needed in the **ADDITIONAL INFORMATION** section at the end of this form.

4. Will the patient 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.

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

5. Will the patient require follow-up treatments, including time for recovery? ☐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. _____

6. Will 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:

   ____hours per day; ____days per week from (date) _____ through (date) _____

7. Will the condition cause episodic flare-ups periodically prevent the patient from participating in normal daily activities?

   ☐Yes ☐No If 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 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

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

ADDITIONAL INFORMATION (Identify question number with your additional response)

_____ _____

Signature of Health Care Provider *Date*