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

Section I: For Completion by the EMPLOYER (Pittsburgh Board of Education)

Board contact: _____

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

Employee's work location: _____

Employee's essential job functions:

Check if job description is attached: ____

Section II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your 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 due to your serious health condition. The Board requires your response 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 the denial of your FMLA request. 29 C.F.R. § 825.313. You must be given at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name:_____

First *Middle* *Last*

Is this request for Intermittent FMLA leave? No_____Yes _____

Certification of Health Care Provider for Employee's Serious Health Condition (FMLA)

Section III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. 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 employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). Please be sure to sign the form on the last page.

Provider's name:_____

Provider's business address: _____

Type of practice / Medical specialty:_____

Telephone: _____ **Fax**:_____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Mark below as applicable:

   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: _____

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

   No_____Yes ____

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

Employee/Patient Name: _____ *Employee/Patient DOB*: _____

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

3. *Use the information provided by the Employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential job functions or a job description, answer these questions based upon the employee's description of his/her job functions:*

   Is the employee unable to perform any of their job functions due to the condition?
   No _____ Yes_____

   If so, identify the job functions the employee is unable to perform:

4. Describe relevant medical facts, 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):

PART B: AMOUNT OF LEAVE NEEDED

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

   If so, please provide the beginning and end dates for the period of incapacity: _____

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

   If so, are the treatments or the reduced number of hours of work medically necessary?
   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:

Employee/Patient Name: _____ *Employee/Patient DOB*: _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing their job functions? No ____ Yes____

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

   If so, 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 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

8. Is this request for Intermittent FMLA leave? No ____ Yes____

ADDITIONAL INFORMATION: Identify question number with your additional answer.

Employee/Patient Name: _____ *Employee/Patient DOB*: _____

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Signature of Health Care Provider*

Date

Print/Type Name of Health Care Provider*

Phone number / Fax number

**If this form has been completed by one of the following, the supervising/collaborating physician must sign here to verify the accuracy of the information in this form: Medical Doctor in Training (MT), Certified Nurse Midwife (NM), Physician's Assistant (PA-C), Doctor, Nurse Practitioner (DNP), and Certified Registered Nurse Practitioner, (CRNP)*

Signature of Supervising/Collaborating Physician

Date

Print/Type Name of Supervising/Collaborating Physician

Phone number

FAX to 412-622-7981

Employee/Patient Name: _____ *Employee/Patient DOB*: _____