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

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

Board contact: _____

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 to care for a covered family member with a 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*

Your job title: _____ **Regular work schedule**: _____

Your work location: _____

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: _____

Is this request for Intermittent FMLA leave? No_____ Yes _____

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

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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 and 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. **Describe 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 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:

4. **Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery?** No_____ Yes _____

   If so, please provide 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:

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

5. **Will the patient require follow-up treatments, 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, any 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 intermittent basis, if any:

_____ Hour(s) per day; _____ days per week from _____ through _____

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

7. **Will the condition 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, any why such care is medically necessary:

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

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ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER:

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*: _____