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

CANYONS SCHOOL DISTRICT

Complete this form and fax it to: Canyons School District-Human Resources ATTN:Kim McCluskey 801-826-5374

SECTION I: For Completion by the EMPLOYEE

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. If requested by your employer, 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 a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Full Name: _____
First Middle Last

Employee's job title: _____ Work Schedule: _____

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax :(_____) _____

SECTION II: 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).

Be sure to sign the form on the last page.

CONTINUED ON NEXT PAGE

PART A: MEDICAL FACTS OF PATIENT

Approximate date condition began: _____

Probable duration of condition: _____

Mark as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ☐ NO ☐ YES

If yes, list date(s) of admission: _____

Date(s) patient was treated for condition: _____

_____

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

Will 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 yes, state the nature of such treatments and expected duration of treatment: _____

_____

_____

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

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 functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition? ☐ NO ☐ YES
If yes, identify the job functions the employee is unable to perform: _____

_____

_____

Describe other relevant medical facts, if any, 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):

_____

_____

_____

_____

CONTINUED ON NEXT PAGE

PART B: AMOUNT OF LEAVE NEEDED

1. Will the employee be incapacitated for a single continuous period of time, due to his/her medical condition, including time for treatment and recovery? ☐ YES ☐ NO
    a. If yes, estimate the beginning and ending dates for the period of incapacity: _____
    _____

2. Will the employee need to attend follow up treatment appointment or work part-time/on a reduced schedule because of the employee's condition? ☐ YES ☐ NO
    a. If yes, are the treatments or the reduced number of hours of work medically necessary? ☐ Yes ☐ No
    b. If yes, list and estimated treatment schedule, if any, and include the dates of schedule appointments and time request for each appointment/recovery period: _____
    _____
    _____
    c. Estimate the part-time/reduced work schedule the employee needs while being treated, if applicable:
    _____ Hours per day _____ days per week
    Date Time Frame: _____

3. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job responsibilities? ☐ YES ☐ NO

4. Is it medically necessary for the employee to be absent from work during the flare ups? ☐ YES ☐ NO
    a. If yes, explain: _____
    _____
    _____

5. 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 of condition: _____

_____

ADDITIONAL INFORMATION: *List question number you need to expand upon*

_____

_____

_____

_____

_____

_____

CONTINUED ON NEXT PAGE

Signature of Health Care Provider

Date

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29

C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210.

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.