Certification of Health Care Provider for
Family Member'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: Ken Anderson, 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 to care for a covered family member with a 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).

Employee's Name: ____
First Middle Last

Family Member's Name: ____
First Middle Last

Employee's relationship to Family Member: ______________________________

If family member is your child, list their date of birth: ______________________

Describe care you will provide to your family member:

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*** **Fill out Healthcare provider's information on Page 2******

______________________________ ______________________
Employee's Signature Date

SECTION II: For Completion by 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).

Healthcare Provider's Name: ____________________
Healthcare Provider's Address: ____________________
Type of Practice/Medical Specialty: ____________________
Phone Number: ____________________ Fax Number: ____________________

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: ____________________
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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/treatment? (e.g., physical therapist)? ☐ NO ☐ YES

If yes, state the nature and expected duration of the treatment(s): ____________________
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Is the medical condition pregnancy? ☐ NO ☐ YES if yes, list the expected delivery date: ____________________

Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):
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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.

1. Will the patient 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: ____________________________

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b. During this time, will the patient need care? ☐ YES ☐ NO

c. Explain the care needed by the patient and why the care is medically necessary:

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2. Will the patient require follow up treatments, including time for recovery? ☐ YES ☐ NO

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

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b. Explain the care needed by the patient, and why such care is medically necessary:____________________

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3. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?
☐ YES ☐ NO

a. Estimate the part-time/reduced work schedule the employee needs while being treated, if applicable:
Date Start and End: ________________________ Hours per day: _______ Days per week: ______________

b. Explain the care needed by the patient, and why such care is medically necessary: ____________________

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4. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activity? ☐ YES ☐ NO

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)

a. Frequency of condition:____

b. Duration of each episode (hours to days): ____________________________________

c. Does the patient need care during these flare-ups? ☐ YES ☐ NO

d. Explain the care needed by the patient, and why such care is medically necessary: ____________________

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Any additional information regarding the patient? ____

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Fax to Ken Anderson with Canyons School District – Human Resources at 801-826-5374 when completed and signed.

If you have any questions about the form, contact Ken at ken.anderson@canyonsdistrict.org or at 801-826-5458

______________________________________ ___________________________

Healthcare Provider Signature Date