THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA
CERTIFICATION OF HEALTH CARE PROVIDER
FOR EMPLOYEE'S SERIOUS HEALTH CONDITION
(FAMILY AND MEDICAL LEAVE ACT)

INSTRUCTIONS to the EMPLOYEE:
Please complete Questions 1-8 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 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 fifteen (15) calendar days to return this form. 29 C.F.R. § 825.305(b).

1. ______________________________ **Employee's Name**

2. ______________________________ **Employee's Personnel Number**

3. ______________________________ **Work Location Name**

4. ______________________________ **Employee's Job Title**

5. Employee's Essential Job Functions: ______________________________

6. Employee's Regular Work Schedule: ______________________________

7. Check if Job Description Attached: ________

8. ______________________________ **Employee's Signature**

______________________________ **Date**

INSTRUCTIONS to 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. Page Two (2) provides space for additional information, should you need it.* ***Please be sure to sign the form on the last page.***

1. Provider's Name:
____

2. Provider's Business Address:
____
____

3. ______________________________ **Type of Practice/Medical Specialty**

4. ______________________________ **Telephone Number** **Fax Number**

PART A: MEDICAL FACTS

5. Approximate date condition commenced: ______________________________

Probable duration of condition: ______________________________

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

____

____

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

7. Use the information provided by the employee in Section 1 to answer this question. If the employee's essential job functions or job description is not provided, answer these questions based upon the employee's own description of his/her functions.

Is the employee unable to perform any of his/her job functions due to the condition: _____ No _____ Yes
If so, identify the job functions the employee is unable to perform: ______________________________

____

8. 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): ______________________________

____

PART B: AMOUNT OF LEAVE NEEDED

9. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? _____ No _____ Yes

If so, estimate the beginning __________ and ending __________ dates for the period of incapacity.

10. 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: ______________________________

____

Estimate the part-time or reduced work schedule the employee needs, if any: ________ hour(s) per day;

________ days per week from ____________ through ____________

11. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her 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 six (6) months (e.g., 1 episode every three (3) months lasting 1-2 days):

Frequency: ________ times per ________ week(s) ________ month(s)

Duration: ________ hours or ________ day(s) per episode

12. ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER. ______________________________

____

____

______________________________________ ______________________

Signature of Health Care Provider **Date**