

## Family and Medical Leave Act

### Family Member Serious Health Condition Certification

#### SECTION 1: TO BE COMPLETED BY EMPLOYEE

**INSTRUCTIONS:** Please complete Section 1 and then provide it to your family member's health care provider. Section 2 must be completed by the treating health care provider; it is inappropriate for you or the family member to complete section 2.

The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for an absence that may qualify as FMLA leave to care for a covered family member with a serious health condition. Your response is required to obtain or retain the benefit of FMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request.

If this is a request for leave to care for an adult child, an *Adult Child Certification of Disability* must also be completed. If this is a request for leave for yourself or a serious injury or illness for a covered service member, do not use this form. Obtain these forms from your human resources office, if needed.

Employee Name		Personnel Number	
Agency		Work Location	
Family Member / Patient Name	Relationship to Employee	If Son/Daughter, Date of Birth	

Describe the care you will provide to your family member and estimate the amount of leave needed to provide this care; include a schedule, if possible for intermittent absences.

#### SECTION 2: TO BE COMPLETED BY HEALTH CARE PROVIDER:

**INSTRUCTIONS:** The above employee 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 on 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 response to the condition for which the employee is seeking leave. **Please sign the last page.**

When answering **Amount of Care Needed** questions, **keep in mind the patient's need for care by the employee seeking leave**, which may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. None of the questions on this form require genetic information.

#### Supporting Medical Certification:

1. Approximate date condition commenced	2. Probable duration of condition (be as specific as you can)
3. Approximate date <b>incapacity*</b> commenced	4. Date(s) you treated patient for condition
5. Was patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? <input type="checkbox"/> No <input type="checkbox"/> Yes    If yes, please list most recent date of admission _____ and discharge _____	
6. Will the patient need to have treatment visits at least twice per year due to the condition? <input type="checkbox"/> No <input type="checkbox"/> Yes	
7. Was medication, other than over-the-counter medication, prescribed? <input type="checkbox"/> No <input type="checkbox"/> Yes	
8. Was the patient referred to another health care provider(s) for evaluation or treatment (example: physical therapist)? <input type="checkbox"/> No <input type="checkbox"/> Yes    If yes, state the nature of such treatments and expected duration of treatment.	
9. Is the medical condition pregnancy? <input type="checkbox"/> No <input type="checkbox"/> Yes    If yes, expected delivery date is _____.	

\*Incapacity is the inability to work, attend school or perform other regular daily activities.

**Medical Facts:**

10. Describe 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).

**Amount of Care Needed (see instructions on page 1)**

11. **Full-time Absence** - Was or will patient be incapacitated for a single continuous period of time due to the medical condition, including any time for treatment and recovery?

No  Yes If yes, specify the **begin date** \_\_\_\_\_ and **end date** \_\_\_\_\_ of the period of incapacity.

During this time, will the patient need care?

No  Yes

12. **Absences for Appointments** - Did or will patient need to attend follow-up treatment appointments because of the medical condition?

No  Yes If yes, estimate the appointment schedule, if any. Include the dates of scheduled appointments and the time required for each appointment, including any recovery period.

Can appointments be scheduled during non-work hours?

No  Yes

13. **Absences for Flare-Ups (not part-time absences)**. Will condition cause episodic flare-ups periodically preventing 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 patient may have over the next 6 months. (**Example:** 1 episode every three months lasting 1-2 days in duration).

Frequency: Number of times \_\_\_\_ per week; or Number of times \_\_\_\_ per month

Duration: Number of hours \_\_\_\_ per episode; or Number of days \_\_\_\_ per episode

Does the patient need care during these flare-ups?

No  Yes

14. **Part-Time Absences (not flare-ups)**. Did or will patient require care on an intermittent or reduced time schedule basis including any time for recovery?

No  Yes If yes, estimate the hours the patient needs care on a part-time basis, if any.

Employee is needed to care for patient: \_\_\_\_\_ Hours per day AND \_\_\_\_\_ Days per week

from begin date \_\_\_\_\_ to end date \_\_\_\_\_

15. Explain the care that the employee will provide for the patient during any of the above noted absences and why such care is medically necessary.

By providing my original signature, the undersigned health care provider certifies that the information is true and accurate.

Printed Name of Health Care Provider	Type of Practice/Medical Specialty	License Number
Address		Telephone Number
Name and Title of Staff Member (if form not completed by the Health Care Provider)		Fax Number
Signature of Health Care Provider		Date

**Please return this form to the employee or to:** Dr. Terence P. Meehan , FMLA/SPF Coordinator,  
Neshannock Township School District, 3834 Mitchell Road, New Castle, PA 16105  
Phone: 724-658-4793 Fax: 724-658-1828 Email: tmeehan@ntsd.org