



# MONTOUR

## SCHOOL DISTRICT

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

#### **SECTION I: For Completion by the EMPLOYER (Montour School District).**

Board contact: Susan Sinicki, Human Resources  
412-490-6500 x6235  
412-722-1473 (fax)

#### **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: \_\_\_\_\_  
\_\_\_\_\_

2. Is the medical condition pregnancy? **No** \_\_\_\_\_ **Yes** \_\_\_\_\_ if so, expected delivery date: \_\_\_\_\_



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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:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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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, and 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, and why such care is medically necessary:

\_\_\_\_\_

\_\_\_\_\_



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ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER:

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\_\_\_\_\_  
**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 412-722-1473