



CERTIFICATION OF HEALTH CARE PROVIDER FOR FAMILY AND MEDICAL LEAVE

Employee's Name:	
Employee's Job Title:	Regular Work Schedule:
Employee's Essential Job Functions:	

HEALTH CARE PROVIDER INSTRUCTIONS: 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. Please be sure to sign the form on the last page.

Provider's Name and Business Address:	
Type of Practice or Medical Specialty:	
Telephone:	Fax:

PART A: MEDICAL FACTS

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? YES NO If so, dates of admission:	
Dates you treated the patient for condition:	
Will the patient need to have treatment visits at least twice per year due to the condition?	YES NO
Was medication, other than over-the-counter medication prescribed?	YES NO
Was the patient referred to other health care provider(s) for evaluation or treatment (e.g. physical therapist)? If so, state the nature of such treatments and expected duration of treatment.	YES NO
Is the medical condition pregnancy? Is so, expected delivery date:	YES NO
Use the information provided by the employer regarding the employee's essential functions or 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? If so, identify the job functions the employee is unable to perform:	YES NO



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

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? If so, estimate the beginning and ending dates for the period of incapacity:	YES	NO
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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?	YES	NO
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If so, are the treatments or the reduced number of hours of work medically necessary?	YES	NO
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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 _____

Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions?	YES	NO
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Is it medically necessary for the employee to be absent from work during the flare-ups? If so, explain:	YES	NO
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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



Chimacum School District
Human Resources Department

FMLA-3

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