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

HISD
Leave Administration
PUTTING PEOPLE FIRST

Phone: 713-556-6590
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SECTION I: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section I before giving this form to your family member or his/her 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. 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). Please forward the FMLA Application (if unable to submit online) and Certification of Healthcare Provider (Family Member) to the Houston ISD Leave Administration department by email or fax within the time frame specified by your employer.

Your Name: _____ Your Employee ID:_____
First Middle Last

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: _____

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____

_____ _____
Employee Signature **Date**

SECTION II: For Completion by the HEALTHCARE PROVIDER

INSTRUCTIONS to the HEALTHCARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts 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 patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Page four (4) provides space for additional information, should you need it. 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: _____

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: _____

Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

Will the patient need to have treatment visits at least twice per year due to the condition? ___No ___ Yes

Was the patient referred to other healthcare 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:

_____

_____

_____

Is the medical condition pregnancy? ___No ___Yes. If so, 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). Please Note: If this form is being used to certify the need for leave under the California Family Rights Act, California regulations prohibit the disclosure of the underlying diagnosis of the serious health condition involved without the consent of the patient.

_____

_____

_____

_____

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.

For Continuous FML Requests

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No ___Yes.

   During this time, will the patient need care? ___ No ___ Yes.

   With the understanding that **this FML request is for the employee and not the patient**, please estimate the beginning and ending dates of the **time the employee will need off** to assist during the patient's period of incapacity: _____
   (mm/dd/yyyy - mm/dd/yyyy)

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

   _____

   _____

   _____

For Intermittent FML Requests

5. Will the patient require follow-up treatment, 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, and 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 an intermittent basis, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____
   (mm/dd/yyyy) (mm/dd/yyyy)

   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.

Episodes of incapacity due to illness/flare-ups are estimated to occur:

_____ hour(s) per day; _____ days per week from _____ through _____
(mm/dd/yyyy) (mm/dd/yyyy)

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:

_____

_____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider **Date**

Houston ISD Leave Administration Department
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