Shawnee Public Schools
Certification of Health Care Provider for
Employee's Serious Health Condition

Section I: Shawnee School District ("the School District")

The Family and Medical Leave Act (FMLA) provides that the School District may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider Records and documents relating to medical certifications, re-certifications, or medical histories of employees created for FMLA purposes are treated as confidential medical records and placed in separate files/records from the usual personnel files and in accordance with 29 C.F.R. §1630.14(e)(1), if the Americans with Disabilities Act applies.

Contact: Shawnee Public Schools Human Resources

Phone 405-878-1022 **Fax: 405-273-6818**

Employee's job title: _____

Regular work schedule: _____

Employee's essential job functions: see job description

Check if the job description is attached: XXX

Section II: Employee

Please complete this section before giving this form to your medical provider The FMLA permits the School District 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 the School District, 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. 20 C.F.R. § 825.313. You have at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your full name: _____

Shawnee Public Schools
Section III: 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. Additional space for information, should you need it, is supplied at the end of this form. Please be sure to sign the form on the last page.

Provider's name: _____

Provider's address: _____

Provider's phone: _____ fax: _____

Type of practice/specialty: _____

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? ▢ YES ▢ NO

   If so, please specify dates of admission: _____

   Date(s) you treated the patient for this 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)? ▢ YES ▢ NO

   If so, state the nature of such treatments and expected duration of treatment:

   _____

2. Is the medical condition pregnancy? ▢ YES ▢ NO

   If so, expected delivery date: _____

3. Use the information provided by Shawnee Public Schools in *Section I* above to answer this question.

If Shawnee Public Schools failed 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? ☐ YES ☐ NO

If so, identify the job functions the employee is unable to perform:

_____

4. 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):

_____

_____

5. 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? ☐ **YES** ☐ **NO**

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

Beginning Date: _____ **Ending Date:** _____

6. 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

If so, are the treatments or the reduced number of hours of work medically necessary? ☐ YES ☐ NO

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:

Hours Daily _____ **Days Weekly from** _____ **through** _____

7. **Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions?** ☐ YES ☐ NO

8. **Is it medically necessary for the employee to be absent from work during the flare-ups?** ☐ YES ☐ NO

If so, explain:

_____

_____

Based on 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

Use this space to provide additional information, if necessary:

_____

Signature of Health Care Provider **Date**

_____

Printed Name of Health Care Provider