Shawnee Public Schools
Certification of Health Care Provider for
Family Member'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 to care for a covered family member with a serious health condition to submit a medical certification issued by the covered family member's health care provider. Records and documents relating to medical certifications, re-certifications, or medical histories of covered family members 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 ____________

Section II: Employee

Please complete this section before giving this form to your family member's 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 care for a covered family member with a 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: ____

Name of family member for who you will provide care: ______________________________

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

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Shawnee Public Schools
Section III: Health Care Provider

The employee listed above has requested leave under the FMLA to care for your patient. 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 patient needs 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. 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):
   ____
   ____

4. Will the patient 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: ____________________

   During this time, will the patient need care: ▢ YES ▢ NO

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

5. Will the patient require follow-up treatments, including any time for recovery? ▢ 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:
   ____

   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? ▢ YES ▢ NO

   Estimate the hours the patient needs care on an 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? ▢ YES ▢ NO

   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

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

   ____
   ____
   ____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER:

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Signature of Health Care Provider Date

____
Printed Name of Health Care Provider