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

HISD
Leave Administration
PUTTING PEOPLE FIRST

Phone: 713-556-6590
FAX: 713-556-6966

SECTION I: 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 due to your own 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 to the Leave Administration department by email or fax within the time frame specified by your employer.

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

SECTION II: For Completion by the HEALTHCARE PROVIDER
INSTRUCTIONS to the HEALTHCARE 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). 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: _____

   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 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:

   _____

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. 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: ___No ___ Yes.

   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). 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.

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   _____

   _____

   _____

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PART B: AMOUNT OF LEAVE NEEDED

For Continuous FML Requests

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? ___No ___Yes.

   If so, estimate the beginning and ending dates for the period of incapacity: _____
   (mm/dd/yyyy - mm/dd/yyyy)

For Intermittent FML Requests

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? ___No ___Yes.

   If so, are the treatments or the reduced number of hours of work medically necessary? ___No ___Yes.

   Estimate the part-time/reduced work schedule (**intermittent time off)** the employee needs to attend **appointments**, if any:

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

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

7. Will the condition cause episodic **flare-ups** periodically preventing the employee from performing his/her job functions? ___No ___Yes.

   Is it medically necessary for the employee to be absent from work during the flare-ups?

   ___No ___Yes. If so, explain:

   _____

   _____

   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 **or** 1 YEAR (circle one)

   Episodes of incapacity are estimated to occur (e.g., 1 time per month, 6 hours per episode):

   Frequency: _____ times per _____ week(s) **or** _____ month(s)

   Duration: _____ hours **or** _____ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

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_____

Signature of Healthcare Provider **Date**

Houston ISD Leave Administration Department
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Houston, TX 77092

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FAX: 713-556-6966