THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA
CERTIFICATION OF HEALTH CARE PROVIDER
FOR FAMILY MEMBER'S SERIOUS HEALTH CONDITION
(FAMILY AND MEDICAL LEAVE ACT)

INSTRUCTIONS to the EMPLOYEE: Please complete Questions 1-7 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(b) (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 fifteen (15) calendar days to return this form to your employer. 29 C.F.R. § 825.305

1. _____ **Employee's Name**

2. _____ **Employee's Personnel Number**

3. _____ **Name of family member for whom you will provide care**

4. _____ **Relationship of family member to you**

5. **If family member is your son or daughter, date of birth:** _____

6. **Describe care you will provide to your family member and estimate leave time needed to provide care:**

_____

_____

7. _____ **Employee's Signature**

_____ **Date**

INSTRUCTIONS to the 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 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's family member is seeking leave. Page Two (2) provides space for additional information, should you need it. ***Please be sure to sign the form on the last page.***

1. **Provider's Name:**

_____

2. **Provider's Business Address:**

_____

_____

3. _____ **Type of Practice/Medical Specialty**

4. _____ **Telephone Number** **Fax Number**

PART A: MEDICAL FACTS

5. 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 health care 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**: _____

_____

6. Is the medical condition pregnancy? ____ No ____ Yes If so, expected delivery date: _____

7. 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): _____

_____

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.*

8. Will the patient be incapacitated for a single continuous period of time, including any time for treatment or recovery? ____ No ____ Yes

Estimate the beginning _____ and ending _____ dates for the period of incapacity.

During this time will the patient need care? ____ No ____ Yes

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

_____

9. Will the patient require follow-up treatments, 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: _____

_____

10. Will the patient require care on an **intermittent** or **reduced scheduled** 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 _____

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

_____

11. 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 over the next six (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

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: _____

_____

12. **ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.** _____

_____

_____ _____

Signature of Health Care Provider **Date**