LOS ANGELES UNIFIED SCHOOL DISTRICT
Family and Medical Leave Act

Certification by Health Care Provider of Family Member's Serious Health Condition

SECTION I: For Completion by the SUPERVISOR

INSTRUCTIONS to the SUPERVISOR: The Family and Medical Leave Act (FMLA) provides that an employer 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 health care provider of the covered family member. Please complete Section I before giving this form to your employee. You may not ask the employee to provide more information than allowed under FMLA regulations. Employers must generally maintain records and documents relating to medical certifications, re-certifications, or medical histories of employees family members created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files.

DATE: _____

TO:_____/_____
Employee Employee #

FROM:_____School Site/Division: _____
Supervisor or Administrator

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her medical provider. 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 supervisor, your response is required to obtain or retain the benefit of FMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. Your supervisor must give you at least 15 calendar days to return this form.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requiring genetic information of an individual or family member of an individual, except as specifically allowed by this law. To comply with GINA, do not provide any genetic information when responding to this request for medical information. "Genetic information", as described by GINA, includes an individual or individual's family member's medical history, results of an individual or individual's family member's genetic tests, the fact that an individual or individual's family member sought or received genetic services, and genetic information of a fetus carried to an individual or individual's family member or an embryo lawfully held by an individual or individual's family member receiving assistive reproductive services.

Your name:_____
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:_____

_____

_____

Starting date of absence:_____; Last date of absence (expected):_____

_____ _____
Employee's Signature Date

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under FMLA to care for your patient. Please 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 of the patient for which the employee needs leave. Page 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 yes, dates of admission:_____

Date(s) you treated the patient for the 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., a physical therapist)?
___No ___Yes. If yes, state the nature of such treatments and expected duration of treatment:

_____

_____

_____

2. Is the medical condition pregnancy? ___ No ___ Yes. If yes, 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.):_____

_____

_____

_____

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:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and 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: _____

5. 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: _____

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 _____

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 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

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**

Verification from Health Care Provider

Provide the following information pertaining to your profession:

a) Your Name_____

b) Your Name as Health Care Provider _____ Degree _____

c) Specialty/Type of Practice_____ License #_____

d) Type of License_____ Telephone # (____)_____

e) Address_____Zip _____

Certify to the following: "I certify that I am the treating health care provider for the above-named patient who is under my professional care. All of this information is true and correct to the best of my knowledge."

Original Signature (no stamp): _____ Date: _____