LA PORTE INDEPENDENT SCHOOL DISTRICT
HUMAN RESOURCES DEPARTMENT
FAX: (281) 604-7106

CERTIFICATION OF HEALTH CARE PROVIDER FOR FAMILY MEMBER'S SERIOUS HEALTH CONDITION (FAMILY AND MEDICAL LEAVE ACT)

Section I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: 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 employee's health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306–825.308. Employers must generally maintain records and documents relating to medication certifications, re-certifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer Name and Contact: **La Porte Independent School District**
Candace Olivares
Human Resources Specialist
(281) 604-7112 Fax: (281) 604-7106

Employee's Job Title:_____ Regular Work Schedule: _____

Employee's Essential Job Functions: _____

_____

❒ Job Description Attached

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. 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.

Your Name: _____
First Middle Last

Section III: For Completion by the HEALTH CARE PROVIDER

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 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. Page 3 provides space for additional information, should you need it. **Please be sure to sign the form on the last page.**

1002 San Jacinto, La Porte Texas 77571
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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?
   ❒ Yes ❒ No If yes, provide dates of admission: _____

   Date(s) you treated the patient for condition: _____

   Was medication, other than over-the-counter medication, prescribed? ❒ Yes ❒ No

   Will the patient need to have treatment visits at least twice per year due to the condition? ❒ Yes ❒ No

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
   ❒ Yes ❒ No If yes, state the nature of such treatments and expected durations of treatment:

   _____

   _____

2. Is the medical condition pregnancy? ❒ Yes ❒ No If yes, 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 job functions or a job description, answer the question 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:

_____

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_____

_____

_____

_____

_____

_____

Part B: AMOUNT OF LEAVE NEEDED

5. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ❒ Yes ❒ No

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

   _____

6. Will the patient 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 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:

   _____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ❒ Yes ❒ No

   Is it medically necessary for the employee to be absent from work during the flare-ups? ❒ Yes ❒ No

   If yes, explain: _____

   _____

   _____

   _____

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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

ADDITIONAL INFORMATION: Identify Question Number with Your Additional Answer:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider **Date**

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