Certification of Health Care Provider for
Family Member's Serious Health Condition
(Family and Medical Leave Act)

SECTION I: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section I 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. You must return this form within 15 calendar days from your request. 29 C.F.R. § 825.305(b).

Your name: ____
First Middle Last

Name of family member for whom you will provide care ______________________________
First Middle Last

Relationship of family member to you: ______________________ Date of Birth______________

Describe care you will provide to your family member and estimate leave needed to provide care:

____

____

I authorize the physician or other licensed practitioner to provide medical information about this patient to El Paso Independent School District (EPISD). The requested information is confidential pursuant to Federal and State Law. The information is protected from further disclosure outside of EPISD without written consent of the above individual.

_____________________________________ ______________
Employee Signature Date

SECTION II: 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. Limit your responses to the condition for which the employee is seeking leave. "The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that ***you not provide any genetic information when responding to this request for medical information***. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."

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:_____

2. 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):

3. Estimate the beginning and ending dates for the period of incapacity:__________________________________

4. Does or will the patient require medical assistance that can be provided by this employee? ____Yes____ No

If Yes, Please Explain

Signature of Health Care Provider **Date**

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