

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

U.S. Department of Labor
Wage and Hour Division



OMB Control Number: 1235-0003
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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 due to a serious health condition to submit a medical certification issued by the employee's health care provider. 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 medical certifications, recertifications, 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: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

Check if job description is attached: _____

SECTION II: 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. 20 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).

Your name: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE 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. 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 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:

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):

PART B: AMOUNT OF LEAVE NEEDED

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: _____

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 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? 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 (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

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**



Leave of Absence Request Form

Return Forms to: Human Resources Department, Hazelwood School District
 15955 New Halls Ferry Road, Florissant, MO 63031 P:314.953.5000 F:314.953.5003

Name	Employee ID Number	Phone Number	Hire Date
Address (Street, Apt #)		City, State, Zip	
Job Title		Building and/or Department	

Leave Requested (Review the back of the last page for explanation of leaves)

- Family Medical Leave
 End of Benefit Leave
 Superintendents Leave
 Child Care Leave(Pregnancy/Adoption Leave)
 FMLA Intermittent OR FMLA Continuous
 Worker's Compensation Leave
 Military Leave

Expected Start Date	Expected End Date	Expected Date of Delivery/Child Arrival (Pregnancy/Adoption)	Actual Start Date	Actual Return Date
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Reason for Request

FAMILY MEDICAL LEAVE

- Birth of a child, or adoption or foster care; or A serious health condition making you unable to perform the essential functions of your job; or
 A serious health condition affecting your spouse, child, or parent, for which you are needed to provide care.

END OF BENEFIT LEAVE WILL REQUIRE A LETTER FROM PHYSICIAN STATING REASON FOR ABSENCE.

NO LEAVE WILL BE APPROVED WITHOUT PROPER MEDICAL DOCUMENTATION

Insurance Premiums during Leaves of Absence

FMLA AND WORKER COMPENSATION (Board paid benefits are only available under these two leaves.) Employees are responsible for submitting all payments for which they are normally responsible to ensure that insurance continues during leave. Insurance will cancel if employee portion is unpaid.

END OF BENEFIT LEAVE—ANY TIME NOT COVERED BY FMLA OR WORKER COMPENSATION--Employees are responsible for 100% of insurance premiums, including the board paid portion, to ensure that insurance continues during leave. Insurance will cancel if employee does not submit payments.

DECLINATION OF INSURANCE--If an employee declines to submit payments for insurance during leave of absence, insurance will cancel until they return to work (with no break in service).

Upon signing, please read and review leave information on page 2.

Signature	Date Submitted
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FOR ADMINISTRATIVE USE ONLY

Intermittent Leave is approved for 60 work days during the school year.

Approved Leaves and Duration Estimates

- FMLA begins** _____ **ends** _____
 End of Benefit begins _____ **ends** _____
 Adoption begins _____ ends _____
 Pregnancy Normal Delivery _____ C-Section _____
 Worker Comp begins _____ ends _____
 Military beings _____ ends _____
 New Hire Not FMLA Eligible* _____ ends _____
**1250 previous district worked hours required*

Date medical certification received _____
 Does spouse work for HSD? No Yes
 Will he/she take leave for the same reason? No Yes
 Is medical certification needed? No Yes, by _____

Estimated Days Available: Comp/Sick Days _____ Vacation Days _____ Personal/Option Days _____ Unpaid Days _____

Request Processed by	Date Processed	Application Approved by	Date Processed
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Please Keep A Copy For Your Records

Explanation of Leaves

(Each leave shall only be granted 1 time each year, except Military Leave and Worker Compensation. This explanation of benefits shall not be construed as all inclusive, as employees must refer to their Memorandum of Understanding or Handbook for more specific details.)

A. FAMILY MEDICAL LEAVE OF ABSENCE—Board Paid Benefits for the Duration of this Leave

FMLA requires Hazelwood School District to provide up to 12 weeks of unpaid, job-protected leave to employees that have worked for the district for at least one year, and for 1,250 hours over the previous 12 months. FMLA permits employees to take leave on an intermittent basis or to work a reduced schedule under certain circumstances. Unpaid leave must be granted for any of the following reasons:

- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

The employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if requirements are not met. Prior to an employees return, medical certification must be provided (if leave is taken for employee's own illness) notifying the district of the employees ability to return to work without restrictions.

The district requires all employees to use all paid comp time available during FMLA leave. This paid time off will run concurrently with FMLA. FMLA will run concurrent with all leaves, when an employee is eligible.

B. END OF BENEFIT LEAVE—Board Paid Benefits are Unavailable

All employees of the Hazelwood School District are limited to the various sick leave days and compensable days adopted annually by the Board, whether the injury is work related or not. In the event that an employee requires a longer convalescent period than the sick and compensable days available to the employee, then:

- Prior to the expiration of all comp, sick, and vacation days, the employee **must** request additional uncompensated leave (if additional time off is required);
- The employee shall furnish the Board of Education with all appropriate medical documents; and
- After the employee has used his or her compensable days and sick days, the Board may grant up to an additional ninety (90) calendar days of uncompensated leave. End of Benefit Leave will begin the first day of unpaid leave. **This unpaid time off will run concurrently with FMLA, Pregnancy, and Adoption Leave, if applicable.**

C. PREGNANCY AND ADOPTION LEAVE—Board Paid Benefits are Unavailable

All employees are eligible for leave for the birth, adoption and first-year care of the employee's child upon proper application for a period not to exceed one (1) year. For employees who are eligible for leave under the Family and Medical Leave Act (FMLA), this leave will be applied concurrently to the FMLA leave. It is emphatically the position of the district that this policy is not intended to expand the 12-workweek applicability of the FMLA.

1. The employee giving birth may use compensable leave, if available, for days when the employee is not physically able to return to work, as verified by a physician. Medical certification is not necessary for the first 30 days of the leave but will be required for use of compensable leave beyond the first 30 contractual days. The employee taking this leave for adoption or first-year care of the employee's child may use up to 30 compensable days, if available, during the first 30 days of leave. Otherwise, pregnancy, childcare and adoption leave will be without pay.
2. Childcare and adoption leave will commence on a mutually agreeable date that shall be determined by the superintendent or designee after consultation with the employee.
3. Board-paid benefits will continue through the first 90 days of leave, if the employee qualified for the benefits prior to the leave. After the first 90 calendar days, insurance benefits may be continued at the employee's expense.

D. MILITARY LEAVE—Board Paid Benefits for 30 days ONLY

The district shall grant Military leave as required by law. Employees taking Military Leave shall give either written or verbal notice of the need for military leave unless impossible due to military necessity. The district will require a copy of any written, official orders after the military leave has exceeded 30 days. Written orders must be submitted to the district to collect a regular salary for up to 15 days per fiscal year.

Employees shall be eligible to retain insurance coverage (at their expense after the 30th day of leave) for up to 18 months or until the day after they are required to report for reemployment.

E. WORKER COMPENSATION—Board Paid Benefits for the Duration of this Leave

The district shall grant Worker Compensation as required by law. Employees shall have the option of being paid comp time or being paid under Worker Compensation (66% of regular pay). The district shall hold a position for the employee until the employee is able to return to work with or without restriction. Board paid benefits will continue throughout this period; however, employees must continue to submit their portion of insurance premiums.

EXAMPLE OF USING CONCURRENT LEAVES

An employee takes a Pregnancy/Adoption Leave from July 1 to June 30 and has enough comp time to receive payment through August 15, she/he will be granted leave as follows:

① # of FMLA days requested 60

② # of Eligible FMLA days 60

Eligible Days Calculation (the smaller of the 2 in ② above):

*60 days less the # of days used for FMLA since July 1 60

*# of days remaining within 12 months of birth or adoption 60

③ # of days granted for FMLA 60

④ # of days granted for Pregnancy 365

⑦ Total # of days employee will be out 365

Is medical certification needed? No Yes, by August 1

FMLA begins July 1 ends Sept 28

End of Benefit begins Aug 16 ends Oct 25

Pregnancy Leave begins July 1 ends June 30

Full Benefit payments begin Sept 29 ends June 3