FREDERICK COUNTY PUBLIC SCHOOLS

Certification of Health Care Provider

(Family and Medical Leave Act of 1993)

This Form Must Be Completed By The Health Care Provider. Forms Filled Out By The Patient/ Employee Will Not Be Accepted.

Employee Name	Leave Is Required For SELF FAMILY MEMBER	Patient Name (if for family member)
Please indicate whether this is a(n)	☐ Initial Certification	☐ Recertification

If leave is for a Family Member, please indicate the relationship between the Employee and the patient (include step, half, and "regarded as" relationships with the most closely associated relationship)

☐ Parent ☐ Spouse ☐ Child Under 18, or Incapable of Self Care

Please check the reason for leave

☐ Inpatient Care (including post-discharge recovery)

☐ Absence Plus Treatment (single episode, not expected to reoccur/ require future treatments)

☐ Pregnancy/Birth/Adoption/Foster Care Placement (including postpartum recovery)

☐ Chronic Condition (multiple treatments/ reoccurring conditions)

☐ Permanent/Long-Term Condition (multiple treatments/ continuing care for non-chronic conditions)

☐ Other (specify)

Nature of Illness/Injury (as it relates to the need for FMLA)

Date Condition/Need for Leave Commenced	Probable Duration/ Date Leave Should Terminate	Future/Intermittent Absences Required YES NO

Anticipated Frequency/Duration of Future Intermittent Absences (include any patterns or triggers for leave, such as seasonal conditions)

Complete the below portion only if the leave is required for the Employee's own Serious Health Condition

Is Employee unable to perform any of the essential functions of his/her position, as stated in writing, by the employer? Please specify.

Full Duty Release Date	Is Employee Able To Perform Work Of Any Kind? YES NO	Partial Duty Release Date (if applicable)

If the employee is released for partial duty, please indicate the type of work that the employee may safely perform. Indicate any restrictions, as specifically as possible, next to the type of work employee may be released to.

☐ Sedentary ☐ Medium/Heavy Work ☐ Equipment Restriction

☐ Light Work ☐ Reduced Work Period ☐ Other (specify)

Length of Time Partial Duty is Anticipated to Be Needed For

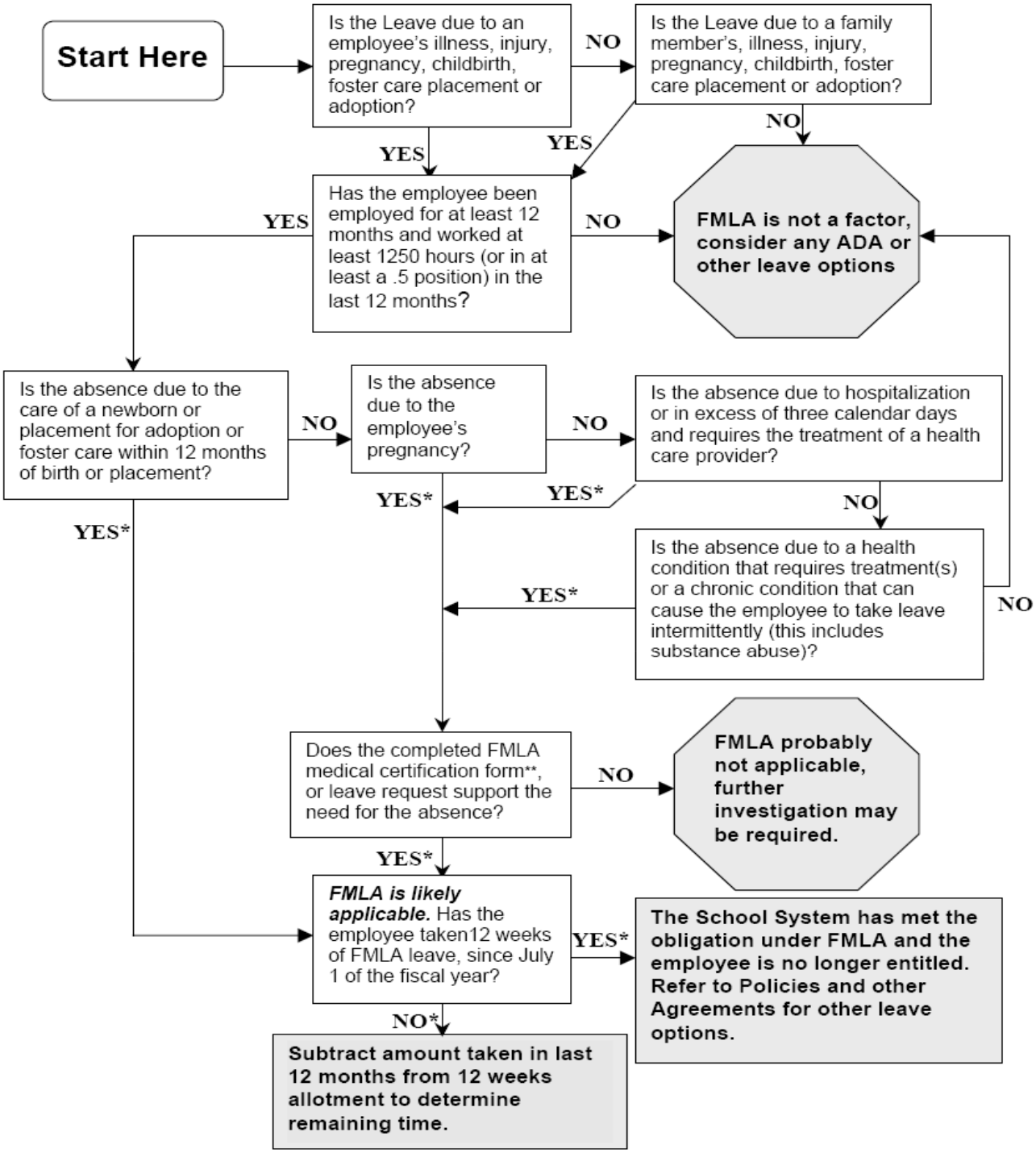
Signatures and Contact Information Required By All

Employee Signature	Date
Health Care Provider Signature	Date
Health Care Provider Name	Phone Number
Address	

RETURN UNDER CONFIDENTIAL COVER TO: Benefit Compliance Officer, 191 South East Street Frederick, MD 21701 Fax 301-644-5122

Form must be returned completed and signed 30 days in advance when practical, and not more than 15 days after the need for leave has been made known in the case of unplanned incidents.

FMLA Decision Tree



*** If any of these apply, please inform the Benefit Compliance Officer.**

** Note that Family and Medical Leave Certification Forms should be kept confidential at all times and must be submitted to Human Resources.