FMLA HEALTH CARE PROVIDER CERTIFICATION

Completed forms can be returned one of the following ways:

- Return to the patient or NJSD employee requesting the leave.
- Fax to NJSD Human Resources Department: (920) 751-5066

EMPLOYEE SECTION

Employee Name: _____
Employer Name: NEENAH JOINT SCHOOL DISTRICT

School: _____ **Job Title:** _____

THIS IS FOR:

☐ **MY OWN SERIOUS HEALTH CONDITION**

My regular work schedule is: _____
Essential Functions of employee's job: _____
_____
My Job description (☐ is / ☐ is not) attached.

☐ **FAMILY MEMBER'S SERIOUS HEALTH CONDITION**

Name of Family Member who needs care: _____
Relationship of the family member to you:
☐ Spouse ☐ Parent ☐ Child, under age 18
☐ Child, age 18 or older and incapable of self-care due to mental or physical disability
Briefly describe the care you will provide your family member: *(Check all that apply)*
☐ Assistance with basic medical, hygienic, nutritional, or safety needs ☐ Transportation
☐ Physical Care ☐ Psychological Comfort ☐ Other: _____
Give your **best estimate** of the amount of leave needed to provide the care described: _____
_____

If a **reduced work schedule** is necessary to provide the care described, give your **best estimate** of the reduced schedule you are able to work. From_____*(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*, I am able to work _____hours per day_____days per week.

This medical certification must be completed and returned at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.

Employee Signature:_____**Date:**_____

HEALTH CARE PROVIDER SECTION

Health Care Provider's Name: (Print) _____
Health Care Provider's Business Address: _____
Type of Practice / Medical Specialty: _____
Telephone: (____) _____ Fax: (____) _____ Email: _____

Medical Information:
Patient's Name: _____
Approximate date the condition started or will start: _____ *(mm/dd/yyyy)*
Best estimate of how long the condition lasted or will last: _____

If this request is for the family member of the patient, for FMLA to apply, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient (e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort). _____
_____

Check the box(es) for the questions below, as applicable. For all box(es) check, the amount of leave needed must be provided in part B.

☐ **Inpatient Care:** The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____

☐ **Incapacity plus Treatment:** (e.g. outpatient surgery, strep throat) Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for more than three consecutive, full calendar days from _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*.

The patient (☐ was / ☐ will be) see on the following date(s): _____
_____

☐ **Pregnancy:** The condition is pregnancy. List the expected delivery date: _____*(mm/dd/yyyy)*

☐ **Chronic Conditions:** (e.g. asthma, migraine headaches) Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Permanent or Long Term Conditions:** (e.g. Alzheimer's, terminal stages of cancer) Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Conditions requiring Multiple Treatments:** (e.g. chemotherapy treatments, restorative surgery) Due to the condition, it is medically necessary for the patient to receive multiple treatments.

☐ **None of the above:** If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 3 to sign and date the form.

If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. *(e.g., use of nebulizer, dialysis)* _____
_____
_____

Amount of Leave Needed: *(Check all that apply)*

Answers 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.

☐ Due to the condition, the patient (☐ had / ☐ will have) **planned medical treatments(s)** (scheduled medical visits) (e.g. psychotherapy, prenatal appointments) on the following date(s): _____

_____

☐ Due to the condition, the patient (☐ was / ☐ will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: *(e.g. cardiologist, physical therapy)* _____

Provide your **best estimate** of the beginning date _____ *(mm/dd/yyyy)* and end date _____ (mm/dd/yyyy) for the treatment(s).

Provide your best estimate of the duration of the treatment(s), including any period(s) of recovery *(e.g. 3 days/week)*

_____

☐ Due to the condition, it is medically necessary for the employee to work a **reduced schedule**.

Provide your **best estimate** of the reduced schedule the employee is able to work. From _____ *(mm/dd/yyyy)* to _____ (mm/dd/yyyy) the employee is able to work: *(e.g., 5 hours/day, up to 25 hours/week)* _____

_____

☐ Due to the condition, the patient (☐ was / ☐ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the period of incapacity.

☐ Due to the condition, it (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur _____ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ (☐ hours / ☐ days) per episode.

Essential Job Functions:

(This section is only to be completed if the employee is the patient.)

If provided, the information in the Employee section may be used to answer this question. If the employer fails to provide a statement of the employee's essential functions or a job description, answer these questions based on the employee's own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be not able to perform the essential job functions of the position during the absence for treatment(s).

Due to the condition, the employee (☐ was not able / ☐ is not able / ☐ will not be able) to perform one or more of the essential job function(s). Identify at least one essential job function the employee is not able to perform: _____

_____

_____

Signature of Health Care Provider: _____ **Date:** _____ *(mm/dd/yyyy)*

Thank you for taking the time to complete this form.
Instructions for returning the completed form are found on page one.