THIS FORM IS TO BE COMPLETED BY THE HEALTH CARE PROVIDER

Attachment 2

CERTIFICATE OF HEALTH CARE PROVIDER
(Family and Medical Leave Act)

This Section For Completion By The Employer

Note to the employer. Employer must generally maintain records and documents relating to medical certifications, recertification, or medical histories of employees created fro FMLA purposes as confidential medical records in separate files/records from the usual personnel files in accordance with 29 C.F.R.§1630.14(c)(1), if the Americans With Disabilities Act applies.

1. Employer name and contact: Greenburgh Eleven UFSD – Dr. Marcia Norton

2. Employee's Name: _____Job Title:_____

3. Regular Work Schedule:_____

Notice to the employee. 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, or a covered family member with a 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 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(b).

If Leave Is Because Of A Family Member, This Section Is For Completion By The Employee

Directions to the employee. After completing this section, give this form to your family member or your family members health care provider to complete.

4. If Patient is not the employee:

   (i) Patient's Name:_____

   (ii) Relationship to Employee:_____

   (iii) If family member is Employee's son or daughter, date of birth:_____

   (iv) Describe the care the Employee will provide for the family member and estimate the leave needed to provide care.

   _____

   _____

   _____

   _____

_____ _____

Employee Signature Date

This Medical Facts Section Is For Completion By The Health Care Provider

Instructions to the Health Care Provider: Your patient (the employee) has requested leave under the FMLA, **or** as the case may be, the employee listed above has requested FMLA leave to care for your patient. Answer fully and completely all applicable parts below. 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 needs or is seeking leave. Pages 4 and 5 provide space for additional information should you need it. **Please be sure to sign the form on the last page.**

5. Approximate date the condition commenced:_____

6. Probable duration of condition:_____

Mark below as applicable:

7. Was the patient admitted for an overnight stay in a hospital, hospice, or residential care facility?

   _____ No _____ Yes. If, yes, provide dates of admission: _____

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

9. Was medication, other than over-the-counter medication, prescribed? _____ No _____ Yes.

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

11. Is the medical condition pregnancy? _____ No _____ Yes. If yes, expected delivery date: _____

12. Was the patient referred to other health care provider(s) for evaluation or treatment (*e.g.*, physical therapist)?

    _____ No _____ Yes. If yes, state the nature of such treatments and expected duration of treatment:

    _____

    _____

13. 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):

_____

_____

_____

_____

_____

_____

_____

14. Employee's Essential Job Functions:

> Due to the special severely emotionally disabled student population at Greenburgh Eleven Union Free School District, work **includes** the capability of performing the essential job functions of therapeutically holding the aggressive and physically out-of-control student(s) and/or running after the student(s).

If patient is the employee, is the employee unable to perform any of his/her job functions due to the condition? ____ No ____ Yes.

If yes, identify the job functions the employee is unable to perform:

_____

<u>This "Amount Of Leave Needed" Section Is For Completion By The Health Care Provider</u>

15. Will the patient 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 yes, estimate the beginning and ending dates for the period of incapacity:_____

> If the patient is the employee's **family member**, during this time will the patient need care? _____ No _____ Yes. If yes, explain the care needed by the patient and why such care is medically necessary:

_____

_____

_____

_____

_____

16. Will the patient require or need to attend follow-up treatments, including any time for recovery? _____ No _____ Yes. If yes, estimate the treatment schedule, if any, including dates of any scheduled appointments and the time required for each appointment including any recovery period:

_____

> If the patient is the employee's **family member**, explain the care needed by the patient and why such care is medically necessary:

_____

_____

17. If patient is the employee, will the employee need to work part-time or on a reduced schedule because of the employee's medical condition? _____ No _____ Yes. If yes:

    (i) Are the treatments or the reduced number of hours of work medically necessary? _____ No _____ Yes.

    (ii) Estimate the part-time or reduced work schedule the employee needs (if any):

    _____hours per day; _____ days per week from _____ through _____

18. If the patient is the employee, will the condition cause episodic flare-ups periodically preventing the patient 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 yes, explain:

    _____

    _____

19. If the patient is the employee's **family member**, will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? _____ No _____ Yes

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20. If the answer to question 18 or 19 is "Yes", 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.

21. If the patient is the employee's **family member**, does the patient need care during these flare-ups?

    _____ No _____ Yes. If yes, explain the care needed by the patient and why such care is medically necessary:

    _____

    _____

    _____

    _____

22. If the patient is the employee's **family member**, will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? _____ No _____ Yes. If yes:

    (i) Estimate the hours the patient needs care on an intermittent basis, if any:

    _____hours per day; _____ days per week from _____ through _____

(ii) Explain the care needed by the patient, and why such care is medically necessary:

23. **Additional Information:** Identify Question Number With Your Additional Answer.

(Signature of Health Care Provider)

(Type of Practice)

(Address)

(Telephone Number)

(Date)

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