BALTIMORE CITY PUBLIC SCHOOLS
CERTIFICATION OF FAMILY AND MEDICAL LEAVE
FOR EMPLOYEE’S SERIOUS HEALTH CONDITION

SECTION I: For Completion by the EMPLOYEE (PLEASE PRINT LEGIBLY)

<table>
<thead>
<tr>
<th>Employee’s Name:</th>
<th>Job Title: P/T or F/T 10 mo or 12 mo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location:</td>
<td>Name of Supervisor/Principal:</td>
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(1) Obtain Job Description from Location or Leaves Management.

(2) Employees essential job functions (if no job description was able to be obtained)

___________________________________________________________________________

INSTRUCTIONS to the EMPLOYEE: Please give this form to your Health Care Provider for completion. The Family and Medical Leave Act (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. Your response is required to obtain or retain the benefit of FMLA protections. Failure to provide a timely, complete and sufficient medical certification may result in a denial of your FMLA request. Your employer must give you at least 15 calendar days to return this form.

For more information on the FMLA, visit the Department of Labor’s website at http://www.dol.gov/compliance/laws/comp-fmla.htm

Genetic Information Nondiscrimination Act of 2008 (GINA) Statement
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.

SECTION II: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the TREATING HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Fully and completely answer all applicable parts, paying attention to the specific points listed here (complete and sufficient responses will eliminate having the form returned to you for clarity). Limit your responses to the condition for which the employee is seeking leave.

*Please be sure to sign the last page.
- Your 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. You may be requested to clarify your answer if these terms are used.

[PLEASE READ THE ABOVE, PRIOR TO COMPLETING FORM]
SECTION II: For Completion by the HEALTH CARE PROVIDER (continued)

Patient’s Full Name: _________________________________________

Treating Health Care Provider’s name: ____________________________

Treating Health Care Providers contact: (Phone)____________________ (Fax)____________________

Treating Health Care Providers business address: ________________________________

Type of practice/ Medical specialty: ____________________________________________

PART A: MEDICAL FACTS

1. I certify that ____________________________________________________________

   □ Does have a serious health condition and qualifies under the category checked below:

   1) _____ 2) _____ 3) _____ 4) _____ 5) _____ 6) _____

   □ Does not have a serious health condition. Provide signature and return form to employee.

2. Approximate date condition commenced: _________________________________

   Most Recent Date(s) you treated the patient for this condition: _______________________

   Probable duration of condition*: ________________________________________________

   *Be as specific as you can; terms such as “lifetime,” “unknown,” or “indeterminate” may not be sufficient to determine FMLA coverage. You may be requested to clarify your answer if these terms are used.

   If for pregnancy, indicate expected delivery date: _____________________________

Describe the medical facts regarding the serious health condition that impede the employee’s ability to work (e.g. symptoms, diagnosis, or any regimen of continuing treatment):

____________________________________________________________________________________

____________________________________________________________________________________

Is the employee unable to perform any of his/her job functions due to the condition? YES ___ NO ___

If YES, explain the specific limitations preventing the employee from performing his/her job functions, and identify the job functions the employee is unable to perform (if necessary, use additional space on the last page of the form):

____________________________________________________________________________________

____________________________________________________________________________________

PART B: AMOUNT OF LEAVE NEEDED ( 5-Continuous, 6-Intermittent, 7-Reduced Work Schedule)

Continuous Leave

5a. 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? YES ___________ NO ___________

   If YES: Estimated Incapacitation Begin Date: _________ Estimated Incapacitation End Date: _________
5b. Will it be medically necessary for the employee to attend follow-up treatment appointments at the end of the continuous (incapacitation) leave? (Please circle one) Yes____ No____ Unable to determine at this time

   If YES, estimate treatment schedule, if any, including the estimated frequency of appointments and the estimated time required for each appointment, including any recovery period:

   Estimated Treatment Begin Date: ___________  Estimated Treatment End Date: ___________
   Frequency: ______ times per week   OR   ______ times per month
   Duration: ______ hours per day   OR   ______ days per episode

Intermittent Leave

6. Will the condition make it medically necessary for the employee to take intermittent leave?

   YES_______ NO _______

   If YES, based upon the patient’s medical history and your knowledge of the medical condition, estimate the frequency of the 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):

   Estimated Intermittent
   Begin Date: ___________  Estimated Treatment End Date: ___________
   Frequency: ______ times per week   OR   ______ times per month
   Duration: ______ hours per day   OR   ______ days per episode

Reduced Work Schedule

7. Will the employee need a reduced work schedule? (Please circle one) YES______NO _______

   If YES, estimate the part-time or reduced work schedule the employee needs, if any:

   Estimated Reduced Schedule Begin Date: ______ Estimated Reduced Schedule End Date: ______
   Frequency: ______ hours per episode  OR  ________ days per week

ADDITIONAL INFORMATION (Please identify question number when responding):
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Signature of Health Care Provider_________________________  Date_________________________

TREATING PHYSICIAN: Please return a complete, sufficient and timely form to employee as to not delay in the processing of the FMLA request. In some cases employee may request documents be sent directly to employer:
Baltimore City Public Schools
Attn: Leaves Management
200 E. North Ave., Rm. 110
Baltimore, MD 21202
Fax: 410-545-0897