# BALTIMORE CITY PUBLIC SCHOOLS

## CERTIFICATION OF FAMILY AND MEDICAL LEAVE

### FOR ELIGIBLE FAMILY MEMBER’S SERIOUS HEALTH CONDITION

### SECTION I: For Completion by the EMPLOYEE

<table>
<thead>
<tr>
<th>Employee’s Name:</th>
<th>Job Title:</th>
<th>P/T or F/T</th>
<th>10 mo or 12 mo employee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location:</td>
<td>Name of Supervisor/Principal:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### INSTRUCTIONS to the EMPLOYEE: Please complete page one (1) before giving this form to your family member or his/her Health Care Provider.

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 to care for an eligible family member with a 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](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.

Name of family member for whom you will provide care: ________________________

Relationship of family member to you: __________________________

First                        Last

If family member is your son or daughter, date of birth: ___________________________

Describe the care you will provide to your family member, and estimate the amount of leave needed to provide care:

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

Employee Signature ___________________________ Date ___________________________
SECTION II: For Completion by the TREATING HEALTH CARE PROVIDER

INSTRUCTIONS to the TREATING HEALTH CARE PROVIDER: The employee listed on page one has requested leave under the FMLA to care for your patient. 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.

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.

Treating Health Care Provider’s name: ____________________________________________ (please print)

Treating Health Care Provider’s business address: ______________________________________________

Type of practice/ Medical specialty: ______________________________

Telephone (_____)____________________ Fax: (_____)____________________

PART A: MEDICAL FACTS

1. I certify that ____________________________________________
   Relationship to Employee ____________________________________________

   □ Does have a serious health condition (see definitions described on page 5)* and qualifies under the category checked below:
   1)____ 2)____ 3)____ 4)____ 5)____ 6)____

   □ Does not have a serious health condition (see definitions described on page 5).* Provide signature on page 4 and return form to address listed.

*Page 5 which describes what is meant by a "serious health condition" under the Family and Medical Leave Act.

2. Approximate date condition commenced: ______________________________
   Most Recent Date(s) you treated the patient for this condition: ______________________________
   Probable duration of condition*: ______________________________

3. Describe the relevant medical facts, if any, related to the condition which requires the employee to care for the patient (e.g. symptoms, diagnosis, or any regimen of continuing treatment):
   ____________________________________________
   ____________________________________________
   ____________________________________________

   Name of Employee ____________________________________________

Based on U.S, DOL form WH-380-E Revised June 2020
Baltimore City Public Schools-September 28, 2020
PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient’s need for care by the employee seeking leave may include assistance with basic medical, hygiene, nutritional, safety or transportation needs, or the provision of physical or psychological care.

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery?
   YES______ NO ______
   If YES: Estimated Incapacity Begin Date: __________  Estimated Incapacity End Date: __________
   During this time, will the patient need care by the employee? YES ______ NO ______ (if NO, go to question #5)
   If YES, explain the care needed by the patient which employee will give.
   A. Is employees need to care for your patient continuously, for the duration of the above date range or continuous for a different date range? Please specify.
   B. Is the employees need to care for your patient on an intermittent basis? If so, please fully complete question #6b.

___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

5. Will the patient require follow-up treatments, including any time for recovery?
   YES ______ NO ______ (if NO, go to question #6)
   If YES, estimate the treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
If YES, explain the care needed by the patient that the employee will give:
___________________________________________________________________________________
___________________________________________________________________________________

6a. Will the condition periodically prevent the patient from participating in normal daily activities?
   YES______ NO ______
   If YES, does the patient need care during these periods of incapacity? YES______ NO ______
   If YES, explain the care needed by the patient by the employee: ________________________________
___________________________________________________________________________________
Name of Employee: ___________________________________________

6b. Based upon the patient’s medical history and your knowledge of the medical condition, estimate the frequency of the related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days)*:

*Please note: The determination of whether intermittent leave is appropriate for the employee caring for your patient will be determined based on the information listed below.

Frequency: ______times per week       OR       ______ times per month
Duration: _______hours per episode   OR       ______ days per episode

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

______________________________            _____________________________
Signature of Treating Specialist                     Date

TREATING PHYSICIAN: Please return a complete, sufficient and timely form to employee as to not delay in the processing of the FMLA request. Completed documents can be emailed directly to humancapital@bcps.k12.md.us as well as sent to the employee for their own records.