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

Employee's Name:	**Job Title:** **P/T or F/T 10 mo or 12 mo employee**
Location:	**Name of Supervisor/Principal:**

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

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: ________________ ____________________
First Last

Relationship of family member to you:____

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:

____

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____

____

______________________________ ______________________
Employee Signature Date

Name of Employee**:** ________________________________

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):

____

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Name of Employee ______________________________________

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.

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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:

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____

____

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):

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______________________________________ ______________________________________

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

Defined Serious Health Condition under the Family and Medical Leave Act.

Family and Medical Leave Act of 1993: **Section 825.800 Definitions-Subpart H**

A ***"Serious Health Condition"*** means an illness, injury, impairment, or physical or mental condition that involves one of the following: A serious health condition involving continuing treatment by a health care provider includes any one or more of the following:

1. **Hospital Care**
   Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. **Incapacity Plus Treatment**
   A period of incapacity (the term *incapacity* means inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery there from) of **more than three consecutive, full calendar days**, ***and*** any subsequent treatment or period of incapacity relating to the same condition, that also involves:
   a. Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity, unless extenuating circumstances exist. **The first (or only) in-person treatment visit must take place within seven days of the first day of incapacity**; or

   b. **At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity,** which results in a regimen of continuing **treatment** under the supervision of a health care provider.

3. **Pregnancy or Prenatal Care**
   Any period of incapacity due to **pregnancy**, or for **prenatal care**.

4. **Chronic Conditions**
   Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches.
   A chronic serious health condition is one which requires **periodic visits** (defined as at least twice a year) for treatment by a health care
   provider, or by a nurse or physician's assistant under direct supervision of a health care provider. Continues over an **extended period of time**
   (including recurring episodes of a single underlying condition); May cause **episodic** rather than a continuing period of incapacity.

5. **Permanent/Long-Term Conditions Requiring Supervision**
   A period of incapacity which is **permanent** or **long-term** due to a condition for which treatment may not be effective. The employee or family member **must be under the continuing supervision of a health care provider**. *Examples include*: Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. **Multiple Treatments (Non-Chronic Conditions)**
   Restorative surgery after an accident or other injuries, or for a condition that **would likely result in a period of incapacity of more than three consecutive, full calendar days in the absence of medical intervention or treatment**, *such as* cancer (chemotherapy, radiation, etc), severe arthritis (physical therapy), or kidney disease (dialysis).