

**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)

Employee’s Name:	Job Title: P/T or F/T 10 mo or 12 mo employee
Location:	Name of Supervisor/Principal:
(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.

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

Treating Health Care Providers business address: _____

Type of practice/ Medical specialty: _____

Telephone (_____) _____ Fax: (_____) _____

Name of Employee: _____

PART A: MEDICAL FACTS (please fully and completely fill out the certification as stated in the instructions)

1. I certify that _____

Does have a *serious health condition* (see definitions described on page 4).* 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 4).* Provide signature and return form to employee.

**Page 4 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*: _____

*** 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: _____

3. 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):

4. 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?

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 Intermittent **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? 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.

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).