# Certification of Health Care Provider for **Employee's** Serious Health Condition
(Physician's Statement)

*Please type or print clearly.*
*To be completed **only** by physician or his/her designated staff member*

Employee/Patient's Name: _____
LAST FIRST MIDDLE

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. 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 is seeking leave. **Please be sure to sign and date this form.**

Provider's name (please print): _____
Provider's business address: _____
Type of practice / Medical specialty: _____
Telephone: (_____) _____ Fax: (_____) _____

1. Describe the nature of the illness or injury (precise diagnosis is required). If for emotional or behavioral illness, use Diagnostic Codes

_____

_____

Approximate date condition commenced: _____
Probable duration of condition: _____
Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ____ No ____ Yes
If so, dates of admission:

_____

Date(s) you treated the patient for condition:

_____

Is surgery required? ____ No ____ Yes
If so, date and type of surgery:

_____

Will the patient need to have treatment visits at least twice per year due to the condition? ____ No ____ Yes
Was medication, other than over-the-counter medication, prescribed? ____ No ____ Yes
If so, please list the medications:

_____

Was the patient referred to other healthcare provider(s) for evaluation or treatment (e.g., physical therapist)? ____ No ____ Yes
If so, state the nature of such treatments and expected duration of treatment:

_____

_____

_____

2. Describe other relevant medical facts related to the condition for which the patient needs care. Such medical facts may include symptoms, detailed treatment plan, or any regimen of continuing treatment (such as the use of specialized equipment):

_____

_____

_____

3. Is the medical condition pregnancy? ___ No ___ Yes If so, expected delivery date: _____

4. Answer these questions based upon the employee's own description of his/her job functions.
   Is the employee unable to perform any of his/her job functions due to the condition? ___ No ___ Yes
   If so, identify the job functions the employee is unable to perform:

   _____

   _____

   _____

5. 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? ___ No ___Yes
   If so, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___ No ___ Yes
   If so, are the treatments or the reduced number of hours of work medically necessary? ___ No ___ Yes
   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

   _____

   Estimate the part-time or reduced work schedule the employee needs, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions?
   ___ No ___ Yes
   Is it medically necessary for the employee to be absent from work during flare-ups? ___ No ___ Yes
   If so, explain:

   _____

   _____

   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

8. Anticipated date of return to work: _____

_____ _____

**Signature of Health Care Provider** **Date Signed**

This form may be faxed (813-794-2078) or emailed (myleaves@pasco.k12.fl.us) to the Office for Human Resources and Educator Quality (HREQ), Leaves Administration Section . It must have a cover sheet indicating it originates directly from the physician's office.