MIS Form #307-D
Rev. 02/18

Certification of Health Care Provider for
Family Member'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's Name: _____
LAST FIRST MIDDLE

Family Member/Patient's Name: _____
LAST FIRST MIDDLE

Relationship of Family Member to Employee: _____

If Family Member is employee's son or daughter, date of birth: _____

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. 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. **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? If so, dates of admission: __ No ___ Yes

_____

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

_____

_____

_____

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. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery?
___No ___ Yes If so, estimate the beginning and ending dates for the period of incapacity: _____
During this time, will the patient need care? ___No ___Yes
Explain the care needed by the patient and why such care is medically necessary:
_____
_____
_____

4. Will the patient require follow-up treatments, including any time for recovery? ___ 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. _____
_____

5. Will the patient require care on an intermittent or reduced schedule basis, including any time for recover ? No___ Yes___
Estimate the hours the patient needs care on an intermittent basis, if any:
_____ hour(s) per day; _____ days per week from _____ through _____
Explain the care needed by the patient, and why such care is medically necessary:
_____
_____

6. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities?
___ No ___Yes
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
Does the patient need care during these flare-ups? ___ No ___ Yes
Explain the care needed by the patient, and why such care is medically necessary: _____
_____
_____
_____

7. Employee's 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.