The School Board of St. Lucie County, Florida

MEDICAL CERTIFICATION STATEMENT

This certification is for the serious health condition of the St. Lucie County Public Schools Employee or family member stated below:

EMPLOYEE

Employee Name: _____ Job Title: _____

Employee Work Location: _____

FAMILY MEMBER

Family Member for Whom You Will Provide Care _____

Relationship of Family Member to You _____ Date of Birth: _____

If the family member is your son or daughter, provide date of birth _____

INSTRUCTIONS FOR HEALTH CARE PROVIDER: The employee listed above 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 "undetermined" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). *Please be sure to sign the form on the last page.*

HEALTH CARE PROVIDER INFORMATION

Provider's name and business address: _____

_____

Type of practice/ Medical Specialty: _____

Telephone: (___) _____ Fax: (___) _____

PART I. MEDICAL FACTS

1. Please state the 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: _____

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 health care 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. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____
3. Is the patient 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 or any limitations this health condition imposes on the employee/patient: _____

_____

4. Please describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

5. Describe the serious medical condition for which the employee seeks leave to care for an immediate family member.

PART II. AMOUNT OF LEAVE/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, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care.

6. Will the employee/patient 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:
(If leave estimated end date cannot be determined provide us the date of the next evaluation.)

7. Will the employee/patient need to attend follow-up treatment appointments, work part-time, or be on a reduced schedule because of the employee's/patient's medical condition? ____ No ____ Yes.
If so, are the treatments or the reduced number of hours of work medically necessary?
____ No ____ Yes.

8. 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 the flare-ups?
____ No ____ Yes. If so, explain:

9. Will the patient require care on an **intermittent** or **reduced schedule** basis, including any time for recovery?
____ No ____ Yes. Estimate the hours the patient needs care on an **intermittent** basis, if any:

Hour(s) per day _____ day(s) per week _____ from (date) _____ through (date) _____
Explain the care needed by the patient, and why such care is medically necessary.

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 incur over the next six (6) months (e.g., episode every three (3) months lasting 1-2 days):

Frequency: time per week(s) _____ times per month(s) _____

Duration: hour(s) _____ day(s) per episode _____

PART III. ADDITIONAL INFORMATION: Please identify the question number with your additional answer.

Signature of Health Care Provider **Date**