CERTIFICATION OF HEALTH CARE PROVIDER FOR FAMILY MEMBER'S SERIOUS HEALTH CONDITION FAMILY AND MEDICAL LEAVE ACT

Form WH-380-F San Angelo ISD Revised December 2009

Section I: For Completion by the *EMPLOYER*

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the employee's health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306–825.308. Employers must generally maintain records and documents relating to medication certifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer Name and Contact: San Angelo Independent School District 1621 University Avenue San Angelo, TX 76904

Section II: For Completion by the EMPLOYEE

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INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her medical provider. The 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. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections, 29 U.S.C. §§ 2613, 2614 (c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. §825.305.

| Your Name: | First | Middle | | Last | |
|---|--|---|--|---|--|
| Name of family member | for whom you w | ill provide care: | | | |
| | · | - | First | Middle | Last |
| Relationship of family m | ember to you: | | | | |
| If family member is | your son or daug | ther, date of birth: | | | |
| Describe care you will p | rovide to your fa | mily member and estin | mate leave n | eeded to provide car | e: |
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| | | | | | |
| | | | | | |
| Employee Signature | | | | Date | |
| Section III: For Compl | etion by the <i>HE</i> . | ALTH CARE PROVI | DER | | |
| INSTRUCTIONS to the HE A Answer, fully and completely, Your answer should be your be terms such as "lifetime," "unkn for which the patient needs lea | all applicable parts b est estimate based up nown," or "indetermin | elow. Several questions see on your medical knowledge nate" may not be sufficient | k a response as , experience, a to determine F | to frequency or duration nd examination of the pati MLA coverage. Limit you | of a condition, treatment, etc. ent. Be as specific as you can ir responses to the condition |
| Provider's Name and Bu | siness Address: | | | | |
| | | | | | |
| Type of Practice / Medic | al Specialty: | | | | |
| Telephone: () | | | Fax: (|) | |

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Part A: Medical Facts

| 1. A | pproximate date condition commenced: |
|------|---|
|] | Probable duration of condition: |
| | Mark below as applicable: Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? |
| I | □ Yes □ No If yes, provide 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? 🗆 Yes 🗖 No |
| , | Was medication, other than over-the-counter medication, prescribed? |
| | Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? Yes INO If yes, state the nature of such treatments and expected durations of treatment: |
| | |
| 2. | Is the medical condition pregnancy? Yes No If yes, expected delivery date: |
| - | |
| - | |
| t | Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment): |
| | |

Part B: Amount of Leave 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.

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? □ Yes □ No

If so, estimate the beginning and ending dates for the period of incapacity:

During this time, will the patient need care:
Yes No

If yes, explain the care needed by the patient and why such care is medically necessary:

5. Will the patient require follow-up treatments, including any time for recovery? \Box Yes \Box No

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:______

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| | Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? | | | | | | |
|---|--|--|--|--|--|--|--|
| | \Box Yes \Box No | | | | | | |
| | Estimate the hours the patient needs care on an intermittent basis, if any: | | | | | | |
| | hours per day;days per week fromthrough | | | | | | |
| | Explain the care needed by the patient, and why such care is medically necessary: | | | | | | |
| | Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? Yes No | | | | | | |
| | 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 orday(s) per episode | | | | | | |
| | Does the patient need care during these flare ups? □ Yes □ No | | | | | | |
| | Explain the care needed by the patient, and why such care is medically necessary: | | | | | | |
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| 1 | litional Information: Identify Question Number with Your Additional Answer | | | | | | |
| | nional mornation. Identify Question Mander with Four Mandelman Missier | | | | | | |
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| | nature of Health Care Provider Date | | | | | | |

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years, 29 U.S.C. § 2616, 29 C.F.K. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW Washington, DC 20210. DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.