ST. VRAIN VALLEY SCHOOLS
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Please return form to:
Department of Human Resources, Leave of Absence
Joe Fowler
395 S. Pratt Pkwy, Longmont, CO 80501
Phone: 303-682-7282
Confidential Fax: 303-682-7399

Certification of Healthcare Provider
For Family Member's Serious Health Condition

TO BE COMPLETED BY EMPLOYEE

Instructions to Employee: Please complete this section 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 to care for a covered family member with a serious health condition. Per SVVSD policy, 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 to your employer. 29 C.F.R. § 825.305.

Name	**SVVSD ID #**
Full Address	**Telephone Number**
Position/Title	**Location/Department**
Employee Type ☐ Classified ☐ Professional/Technical ☐ Licensed ☐ Administrator	**Supervisor**
Expected Last Day Worked	**Expected Return to Work Date**

Full name of family member for whom you will provide care: _____

Relationship of family member to you: _____ If son or daughter, date of birth: _____

Describe care you will provide to your family member: _____

_____

Employee Signature: _____ **Date:** _____

TO BE COMPLETED BY HEALTH CARE PROVIDER

Instructions to the Health Care Provider: The employee listed above has requested leave under the FMLA and/or SVVSD policy to care for your patient. Answer, fully and completely, all applicable parts below. 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 patient needs leave. Please be sure to sign the form on the last page.

MEDICAL FACTS:

1. 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 Yes, 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? ☐ No ☐ Yes
   If Yes, state the nature of such treatments and expected duration of treatment: _____
2. Is the medical condition pregnancy? ☐ No ☐ Yes If Yes, what is the expected delivery date: _____
3. 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): _____

_____

AMOUNT OF 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.

4. Will the 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 Yes, 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: _____

   _____

   _____

5. Will the patient need to attend follow-up treatments including any time for recovery? ☐ No ☐ Yes

   If Yes, estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: _____

   _____

   Explain the care needed by the patient, and why such care is medically necessary: _____

   _____

6. Will the patient require care on an intermittent or reduced schedule basis, including any recovery? ☐ No ☐ Yes

   Estimate the hours the patient needs care on an intermittent basis, if any:

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

   Explain the care needed by the patient, and why such care is medically necessary:

   _____

   _____

2. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ☐ No ☐ Yes

3. 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:

   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

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

   _____

   _____

ADDITIONAL INFORMATION:

_____

_____

Provider's Name and Business Address and Phone	**Type of Practice / Medical Specialty**

Signature of Health Care Provider: _____ **Date:** _____