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

Certification of Healthcare Provider For Employee's Own Serious Health Condition

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

TO BE COMPLETED BY EMPLOYEE

Instructions to Employee: Please complete this section before giving this form to your 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. 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. 20 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(b).

Full 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**

Employee Signature: _____ **Date:** _____

TO BE COMPLETED BY HEALTH CARE PROVIDER

Instructions to the Health Care Provider: Your patient has requested leave under the FMLA and/or SVVSD policy. 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 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: _____

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2. Is the medical condition pregnancy? ☐ No ☐ Yes If Yes, what is the expected delivery date: _____

3. Answer these questions based upon the employee's own description of his/her job functions or use the employee's job description if attached.

   Is the employee unable to perform any of his/her job functions due to the condition: ☐ No ☐ Yes

   If Yes, identify the job functions the employee is unable to perform: _____

4. 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 LEAVE NEEDED:

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 Yes, 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 Yes, 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 begin date _____ through end date _____ .

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 the flare-ups? ☐ No ☐ Yes

   If Yes, 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:

Frequency: _____ times per _____ week(s) month(s) _____ Duration: _____ hours or _____ day(s) per episode

ADDITIONAL INFORMATION: _____

_____

_____

_____

_____

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

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