TUNKHANNOCK AREA SCHOOL DISTRICT

41 PHILADELPHIA AVENUE TUNKHANNOCK PA 18657

Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)

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 due to a serious health condition to submit a medical certification issued by the employee's health care provider.

Employer name	and contact: Tunkl	hannock Area School District and Supe	erintendent of Schools	
Employee's job	title:	Regular v	Regular work schedule:	
Employee's esse	ential job functions	:		
Check if job des	cription is attached	i :		
before giving thi complete, and s condition. If requ protections. 29 t result in a denia	s form to your med ufficient medical ce uested by your emp J.S.C. §§ 2613, 26	lical provider. The FMLA permits an emertification to support a request for FML ployer, your response is required to obta14(c)(3). Failure to provide a complete puest. 20 C.F.R. § 825.313. Your employed.	EMPLOYEE: Please complete Section II apployer to require that you submit a timely, A leave due to your own serious health ain or retain the benefit of FMLA and sufficient medical certification may over must give you at least 15 calendar days	
Your name:				
	(First)	(Middle)	(Last)	
PROVIDER: You Several question be your best est specific as you o	ur patient has requins seek a response imate based upon can; terms such as your responses to	e as to the frequency or duration of a co your medical knowledge, experience, a "lifetime," "unknown," or "indeterminate	fully and completely, all applicable parts. ondition, treatment, etc. Your answer should	
Provider's name	and business add	lress:		
Type of practice	/ Medical specialty	y:		
Telephone: ()	Fax:()	

PART A: MEDICAL FACTS 1. Approximate 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?
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?NoYes
Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
NoYes
If so, state the nature of such treatments and expected duration of treatment:
2. Is the medical condition pregnancy?NoYes If so, expected delivery date:
3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions. Is the employee 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:
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):
PART B: 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?NoYes If so, 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?NoYes.
If so, are the treatments or the reduced number of hours of work medically necessary?NoYes.

each appointment, including any recovery period:	or any scheduled appointment	s and the time required for
Estimate the part-time or reduced work schedule the emp		hour(s) per day;
7. Will the condition cause episodic flare-ups periodically functions?NoYes	preventing the employee from	n performing his/her job
Is it medically necessary for the employee to be absent freexplain:	•	P NoYes If so,
Based upon the patient's medical history and your knowled flare-ups and the duration of related incapacity that the prevery 3 months lasting 1-2 days): Frequency: times	atient may have over the next	6 months (e.g., 1 episode
Duration: hours or day(s) per episode		
ADDITIONAL INFORMATION: IDENTIFY QUESTION NU	UMBER WITH YOUR ADDITION	ONAL ANSWER.
Signature of Health Care Provider :	Date :	