Howard County Public School System

Family and/or Medical Leave (FMLA) Healthcare Provider Certification Form

Note: The information sought on this form pertains only to the condition for which the employee is requesting leave.

To be completed by the Employee/patient

Employee name_____ Employee number_____

Position_____ School/Work Location_____

Patient name (if not employee)_____ Relation to employee ❑ Spouse ❑ Child ❑ Parent

I hereby authorize the undersigned health care provider to release information required to verify my serious health condition. If sufficient information is not provided, I understand that it may be necessary to submit additional information upon request. I understand that failure to submit sufficient information may result in the delay and/or denial of this request.

Employee/Patient Signature_____ Date____/____/_____

To be completed by the health care provider

Physician/Practitioner name_____ Specialization/Type of practice_____

Address_____ Phone_____

Describe the medical facts that support your certification_____

_____

If pregnancy - projected date of delivery ____/____/_____ Illness-Date Condition Commenced* ____/____/_____

Probable Duration of Condition_____ Probable duration of incapacity** ____/____/_____ to ____/____/_____

Certified to return to work without restrictions: ❑ Yes ❑ No If yes, return date ____/____/_____

Will it be medically necessary for the employee to work on an intermittent/reduced schedule due to the condition (including for treatment)? ❑ Yes ❑ No

If employee will miss work because of treatment on an intermittent or reduced schedule, please provide:

1. Probable number of treatments_____ 2. Interval between treatments_____

3. Dates of treatments if known_____ 4. Period of recovery (if any)_____

If the patient requires a regimen of continuing treatment[3] under your supervision, provide a general description of the regimen (e.g., prescription drugs, or physical therapy requiring special equipment). _____

_____

A. If absence from work is required due to the employee's **own** medical condition, including absences related to pregnancy or a chronic condition, is the employee able to perform work of any kind? Please check appropriate response.
   ❑ Able to perform some types of work ❑ Unable to perform work of any kind

B. If able to perform some work, is employee **unable** to perform any one or more essential functions of the job, based on description of essential functions provided by the employer, if any (or, if none, by the employee?) ❑ Yes ❑ No

   If yes, please describe_____

   _____

C. If neither "A" or "B" above, is it necessary for the employee to be absent from work for treatment? [2] ❑ Yes ❑ No

D. If leave is required to care for a **family member** with a serious health condition, does the patient require assistance for basic medical or personal needs, safety, or transportation? ❑ Yes ❑ No

E. If "D" above is "No", would the employee's presence provide psychological comfort and be beneficial to the family member or assist in recovery? ❑ Yes ❑ No

F. If intermittent care is necessary, probable duration of need_____

Healthcare provider's signature (please do not use stamp or designee signature)_____ Date____/____/_____

Complete and return original form to: **Howard County Public Schools, Office of Human Resources**
10910 Clarksville Pike • Ellicott City, MD 21042 • Phone 410-313-6612 • Fax 410-680-3427.