Shawnee Heights USD 450
Family and Medical Leave Certification of Health Care Provider

EMPLOYEE: PLEASE FILL OUT THIS SECTION, AND TAKE THIS FORM TO YOUR HEALTH CARE PROVIDER.

Employee:

Patient (if other than employee): | Relation to Employee:

Begin and end dates of requested leave: _____ to _____ .

HEALTH CARE PROVIDER: PLEASE FILL OUT THIS SECTION AND RETURN AS SHOWN BELOW.

Does the patient have a serious health condition _____ Yes _____ No (If yes, please check reason):

- ☐ 1. Hospital stay
- ☐ 2. Incapacity plus Treatment -- condition that causes 3 days of incapacity and
  - ☐ two or more treatments by a health care provider; or
  - ☐ one treatment plus a continuing regiment under supervision of a health care provider

  Please request employee's job description if needed to determine "incapacity."
- ☐ 3. Pregnancy -- any period of incapacity due to pregnancy or prenatal care
- ☐ 4. Chronic Serious Health Condition
- ☐ 5. Permanent or Long-Term Conditions -- requiring medical supervision
- ☐ 6. Multiple Treatments for Non-Chronic Condition

If the leave is to care for a family member, is the employee's presence necessary or would it be beneficial to the patient?

_____ Yes _____ No

When did the serious health condition begin?

When is the anticipated return to work date?

Is intermittent leave or a reduced work schedule medically necessary? _____ Yes _____ No (If yes, describe):

Name of Health Care Provider:

Specialty:

Signature of Health Care Provider | Date:

Address

PLEASE RETURN THIS FORM TO:

_____ Employee _____ Other:

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2/2014