Little Rock School District
HUMAN RESOURCES DEPARTMENT
EMPLOYEE'S SERIOUS HEALTH CONDITION
Family and Medical Leave Act (FMLA)

HEALTH CARE PROVIDER

Employee Name: *(Print)*_____

Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient has requested leave in accordance with the FMLA. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of the employee. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves *inpatient care* or *continuing treatment by a health care provider*.

Health Care Provider's name: *(Print)*_____

Health Care Provider's business address: _____

Name of business: _____ Type of practice/Medical specialty: _____

Telephone: _____Fax: _____ Email: _____

PART A: – MEDICAL INFORMATION

Limit your response to the medical condition(s) for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition.

(1) State the serious health condition: _____

(2) State the approximate date the condition started or will start: _____*(mm/dd/yyyy)*

(3) Provide your **best estimate** of how long the condition lasted or will last: _____

(4) Check the box(es) for the questions below, as applicable.

For all box(es) checked, the amount of leave needed must be provided in Part B.

☐ **Inpatient Care**: The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s):

_____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*.

☐ **Incapacity plus Treatment**: *(e.g. outpatient surgery, strep throat)*

Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for *more than* three consecutive, full calendar days from _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*.

The patient (☐ was / ☐ will be) seen on the following date(s): _____

The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider *(e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment)*

☐ **Pregnancy**: The condition is pregnancy. List the expected delivery date:_____*(mm/dd/yyyy)*.

☐ **Chronic Conditions**: *(e.g. asthma, migraine headaches)* Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Permanent or Long Term Conditions**: *(e.g. Alzheimer's, terminal stages of cancer)* Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Conditions requiring Multiple Treatments**: (*e.g. chemotherapy treatments, restorative surgery)* Due to the condition, it is medically necessary for the patient to receive multiple treatments.

☐ **None of the above**: If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 3 to sign and date the form.

Little Rock School District
HUMAN RESOURCES DEPARTMENT
EMPLOYEE'S SERIOUS HEALTH CONDITION
Family and Medical Leave Act (FMLA)

HEALTH CARE PROVIDER

Employee Name: *(Print)*_____

(5) Describe other relevant medical facts, if any, related to the condition(s) for which the employee seeks FMLA leave. *(e.g., use of nebulizer, dialysis*)

_____

_____

PART B: AMOUNT OF LEAVE NEEDED

For the medical condition(s) checked in Part A, complete all that apply. 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.**

(6) Due to the condition, the patient (☐ had / ☐ will have) **planned medical treatment(s)** (scheduled medical visits) *(e.g. psychotherapy, prenatal appointments)* on the following date(s): _____

_____

(7) Due to the condition, the patient (☐ was / ☐ will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: *(e.g. cardiologist, physical therapy)* _____

Provide your **best estimate** of the beginning date _____ *(mm/dd/yyyy)*

and end date _____*(mm/dd/yyyy)* for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery *(e.g. 3 days/week)*

_____

(8) Due to the condition, the patient (☐ is / ☐ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date _____ *(mm/dd/yyyy)* and

end date_____ (mm/dd/yyyy) for the period of incapacity.

(9) Due to the condition it, ☐ is /☐ is not medically necessary for the employee to work a **reduced schedule**.

Provide your **best estimate** of the reduced schedule the employee is able to work.

From _____ *(mm/dd/yyy) to* _____ *(mm/dd/yyyy)* the employee is able to work: *(e.g., 5 hours/day, up to 25 hours a week)*

_____

_____

(10) Due to the condition, it (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur_____times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ (☐ hours / ☐ days) per episode.

Little Rock School District
HUMAN RESOURCES DEPARTMENT
EMPLOYEE'S SERIOUS HEALTH CONDITION
Family and Medical Leave Act (FMLA)

HEALTH CARE PROVIDER

Employee Name: *(Print)*_____

PART C: ESSENTIAL JOB FUNCTIONS

Please answer the question below based upon the employee's own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be *not able* to perform the essential job functions of the position during the absence for treatment(s).

(11) Due to the condition, the employee (☐ was not able / ☐ is not able / ☐ will not be able) to perform *one or more* of the essential job function(s). Identify at least one essential job function the employee is not able to perform:

_____

_____

_____

_____

The employer must give the employee at least **15 calendar days** to return the completed medical leave packet.

If the employee fails to provide complete and sufficient medical certification, his or her medical leave request may be denied.

Signature of Health Care Provider:_____ **Date:**_____ *(mm/dd/yyyy)*

Please return this form to the employee or send it to:

LRSD Human Resources Medical Leave
810 W. Markham
Little Rock, Arkansas 72201
Office: 501-447-1100
Fax: 501-447-1162

Little Rock School District
HUMAN RESOURCES DEPARTMENT
EMPLOYEE'S SERIOUS HEALTH CONDITION
Family and Medical Leave Act (FMLA)

HEALTH CARE PROVIDER

Employee Name: *(Print)*_____

Definitions of a Serious Health Condition *(See 29 C.F.R. §§ 825.113-.115)*
Inpatient Care
• An overnight stay in a hospital, hospice, or residential medical care facility. • Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.
▪ **Continuing Treatment by a Health Care Provider (any one or more of the following)**
• **Incapacity Plus Treatment:** A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: • Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, • At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.
Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.
Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

Little Rock School District
HUMAN RESOURCES DEPARTMENT
RETURN TO WORK CERTIFICATION
Medical Leave

HEALTH CARE PROVIDER

Employee Name: *(Print)* _____ Job Title: _____

Health Care Provider's name: *(Print)*_____

Health Care Provider's business address: _____

Name of business_____ Type of practice/Medical specialty: _____

Telephone: _____Fax: _____ Email: _____

Employee is released to return to work effective: _____ *(mm/dd/yyyy)*

Based on the above employee's job title, the employee is able to perform the essential functions of the position?

— Without restrictions or accommodations

— With restrictions or accommodations

Please list any restrictions/limitations or describe accommodations which LRSD should consider:
_____
_____
_____

Are the restrictions/limitations:
— Permanent
— Temporary, until: _____ *(mm/dd/yyyy)*

Comments:
_____
_____
_____
_____

Signature of
Health Care Provider: _____ Date: _____*(mm/dd/yyyy)*

Please return this form to the employee or send it to:

LRSD Human Resources Medical Leave
810 W. Markham
Little Rock, Arkansas 72201
Office: 501-447-1100
Fax: 501-447-1162