Family or Medical Leave Request

Conroe Independent School District *Based on Policy DEC (Local)*

Please type or print

Employee's name ______________________ Position ______________________

Employee Identification # (EIN) ______________________ Date(s) of leave requested ______________________

Campus/Department ______________________ Anticipated return date ______________________

Reason for Leave:

☐ birth of your child or the placement of a child with you for adoption or foster care

☐ a serious health condition that makes you unable to perform the essential functions of your job

Note: *To be eligible, an employee must have worked for Conroe ISD for at least 12 months and have worked at least 1,250 hours in the 12 months immediately preceding the need for leave.*

I have read and understand district policies DEC (Legal) and DEC (Local), Compensation and Benefits: Leaves of Absences. I understand that this leave must be taken concurrently with any other leave to which I am entitled under Board policy. I understand that I must make arrangements with the district Payroll Office to pay for my share of the health insurance benefits. I understand that failure to make timely payments may result in loss of coverage. I also understand that as long as I qualify for FMLA the district will continue to pay my health insurance benefits at the same level and under the same conditions that coverage would have been provided if I had continued in my job.

Employee Signature ______________________ Date ______________________

Administrator Acknowledgement

______________________ ______________________

Principal/Supervisor *Date forwarded to Human Resources Department*

Human Resources Department

☐ Approved FMLA hours __________

☐ Not Approved

Signature: ______________________ Date: ______________________

DEC (L)(E)2

3/23/09

Certification of Health Care Provider for Employee's Serious Health Condition

SECTION I: For completion by the EMPLOYEE

Your name *(PRINT first, middle, last)* ______________________________

______________________________ ______________________________
Employee signature *Date*

SECTION II: For completion by the HEALTH CARE PROVIDER

Instructions for the Health Care Provider: Your patient has requested leave under the FMLA. 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.

Provider's name *(Print)* ______________________________

Provider's business address ______________________________

Type of practice/medical specialty ______________________________ Telephone (_____) ____________________ Fax (_____) ____________________

PART A: MEDICAL FACTS

1. Approximate date condition commenced ______________________ Probable duration of condition ______________________

   Mark below as applicable:

   Was 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 ______________________________

   Was medication, other than over-the-counter medication, prescribed? ☐ *No* ☐ *Yes*

   Will the patient need to have treatment visits at least twice per year due to the condition? ☐ *No* ☐ *Yes*

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ☐ *No* ☐ *Yes*

   If so, state the nature of such treatments and expected duration of treatment ______________________________

2. Is the medical condition pregnancy? ☐ *No* ☐ *Yes* *If so, expected delivery date* ______________________________

3. 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 employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment/recovery? ☐ *No* ☐ *Yes*

   If so, estimate the beginning and ending dates for the period of incapacity ______________________________

6. Will employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of employee's medical condition? ☐ *No* ☐ *Yes*

   If so, are the treatments or the reduced number of hours of work medically necessary? ☐ *No* ☐ *Yes*

   Estimate treatment schedule, if any, including dates of any scheduled appointments and the time required for each appointment, including any recovery period

   ____

   Estimate part-time or reduced work schedule employee needs, if any _______ hour(s) per day; _______ days per week from ____________ through ____________

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* *Yes. If so, 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 *(e.g., 1 episode every 3 months lasting 1-2 days)*

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

______________________________ ______________________________
Health Care Provider signature *Date*