CERTIFICATION OF HEALTH CARE PROVIDER FOR FAMILY MEMBER'S SERIOUS HEALTH CONDITION

Employee's Legal Last Name	Employee's Legal First Name	Employee's EIN

Instructions for the Employee: Complete the personal information above and at the top of pages 2 and 3. Complete and sign this section. The remainder of this form must be completed in its entirety by your family member's health care provider and submitted to the CISD Leave Office no later than 15 calendar days after you submit an *Application for Leave*. **If you fail to provide complete and sufficient certification, your leave request may be denied.** *By submitting this form to your family member's health care provider, you authorize the provider to release the information on this form to the CISD Leave Office for the purpose of determining your eligibility for leave.*

(1) Family member for whom I will provide care: **Name**_____ **Date of Birth** _____

(2) The family member named above is my:

❑ Spouse ❑ Parent ❑ Child under age 18 ❑ Child 18 years or older and incapable of self-care due to a mental or physical disability

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including in a common law marriage or same-sex marriage. The terms "parent" and "child" include in loco parentis relationships in which a person assumes the obligations of a parent to a child. A "child" is defined as a biological, adopted, or foster child, a stepchild, a legal ward, or a child of a person standing in loco parentis who is either under 18 years of age or is 18 years of age or older and "incapable of self-care because of a mental or physical disability" at the time leave is to commence.

(3) My **best estimate** of the amount of leave needed to provide the care described is: _____

(4) A **reduced work schedule** is necessary to provide care. My **best estimate** of the schedule I am able to work is:

_____ (*hours per day*) _____ *(days per week)* from _____ /_____ /_____ *(beginning date)* to _____ /_____ /_____ *(ending date).*

Employee Signature _____ **Date:** _____

Instructions for the Employee's Health Care Provider: A family member of your patient has requested leave to care for your patient because of a serious health condition and must submit a timely, complete, and sufficient medical certification from you to support the leave request. For the purposes of this form, 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*. Please refer to the table below for more information about the definitions of a serious health condition, then complete Parts A and B on pages 2 and 3 of this certification form. Be sure to sign page 3.

Definitions of a Serious Health Care Condition
Inpatient Care: An overnight stay in a hospital, hospice, or residential medical care facility. Inpatient care includes any period of incapacity or 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. *"Incapacity" means the inability to work or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition.*
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.

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The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

PART A: Medical Information (For Completion by the Family Member's Health Care Provider)

Limit your response to the medical condition(s) for which the employee named above is seeking 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.**

(1) Patient's name: _____

(2) Approximate date the condition started or will start: _____ /_____ /_____

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

(4) For leave to apply, care of the patient must be medically necessary. The type of care needed by the patient is: *(Check all that apply)* ❑ Assistance with basic medical, hygienic, nutritional, or safety needs ❑ Transportation ❑ Physical Care ❑ Psychological Comfort ❑ Other: _____

(5) 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 was/is expected to be admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____

_____.

❑ **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 _____ /_____ /_____ to _____ /_____ /_____. The patient was/will be seen on the following date(s):

_____ .

The condition (❑ has also / ❑ has not) 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 expected delivery date is: _____ /_____ /_____.

❑ **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).

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❑ **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**: Skip Part B. Go to the bottom of page 3, print your information, then sign and date the form.

(6) If needed briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks leave. *(e.g., use of nebulizer, dialysis)*: _____

_____

_____

_____

PART B: Amount of Leave Needed (For Completion by the Family Member's Health Care Provider)

For the medical condition(s) checked in Part A, complete all that apply. Your answers 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 leave coverage.

❑ 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): _____

_____ .

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

Nature of such treatments: *(cardiologist, physical therapy)* _____

Treatment beginning date _____ /_____ /_____ and ending date _____ /_____ /_____. Duration of the treatment(s), including any period of recovery *(e.g., 3 days/week)* _____

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

Incapacity period beginning date _____ /_____ /_____ and ending date _____ /_____ /_____.

❑ **INTERMITTENT** Due to the condition, it (❑ was / ❑ 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. Episodes of incapacity are estimated to occur _____ times per (❑ day / ❑ week / ❑ month) and are likely to last approximately _____ (❑ hours / ❑ days) per episode.

Intermittent period beginning date _____ /_____ /_____ and ending date _____ /_____ /_____.

Health Care Provider's Printed Name	Type of practice /medical specialty:
Business address:	
Phone:	Email:

Health Care Provider Signature_____ **Date:** _____