

ATTACHMENT X -

MEDICAL CERTIFICATION FROM HEALTH CARE PROVIDER
FMLA LEAVE

(to be submitted within 15 days of Employee requesting FMLA leave)

Employee's Name: _____ Position: _____

Building: _____

Reason for Employee requesting FMLA leave (circle one):

1. To care for an immediate family member (son, daughter, spouse, or parent) with a serious health condition; or
2. The Employee's own serious health condition prevents him/her from performing the functions of his/her job (i.e. the health care provider determines that the Employee is unable to work at all or is unable to perform any of the essential functions of the Employee's position within the meaning of the Americans with Disabilities Act).

If reason #1 has been circled above, indicate the name and relationship of the immediate family member (patient):

Name of Treating Health Care Provider: _____

Type of Medical Practice (Field of Specialization, if any): _____

Approximate date on which the serious health condition commenced: _____

Probable duration of the condition/incapacity: _____

The attached sheet describes what is meant by a "serious health condition." Does the patient's condition (for which the employee is taking FMLA leave) qualify under any of the categories described? If so, please check the applicable category.

(1)____ (2)____ (3)____ (4)____ (5)____ (6)____, or None of the above _____

Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

Will it be necessary for the employee to work intermittently or on a reduced leave schedule as a result of the condition (including, as a result of treatment): **Y** **N**

If yes, give the probable duration:

If the condition is a chronic condition or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity:

If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments:

To be completed by the Employee requesting FMLA leave for reason #1:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

Employee's Signature

Date

MEDICAL RELEASE:

I authorize my health care provider to complete the above Medical Certification form and to release it to the Westlake City School District Board of Education.

Patient's Signature

Date