

ATTACHMENT XII -  
**MEDICAL CERTIFICATION FROM HEALTH CARE PROVIDER**  
**BOARD REQUESTED SECOND OPINION (OPTIONAL)**  
**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):

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Health Care Provider Consulted: \_\_\_\_\_

Medical Practice (Field of Specialization, if any): \_\_\_\_\_

Date Consulted: \_\_\_\_\_

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:

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If the patient will be absent from work or other daily activities because of treatment on an intermittent or part-time basis, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

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If any of these treatments will be provided by another provider of health services (e.g., physical therapist), please state the nature of the treatments:

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If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

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**If the Employee is taking FMLA leave for reason #2 (including absences due to pregnancy or a chronic condition):**

- A. Is the employee unable to perform work of any kind?                    **Y**        **N**
- B. If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job (the Employee or the Board will provide you with information about the essential job functions)?                    **Y**        **N**
- If yes, please list the essential functions the Employee is unable to perform:

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- C. If neither A. nor B. applies, is it necessary for the employee to be absent from work for treatment?    **Y**    **N**

**If the Employee takes FMLA leave for reason #1:**

- A. Does the patient require assistance for basic medical or personal needs or safety, or for transportation?    **Y**    **N**
- B. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery?    **Y**        **N**
- C. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need:

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\_\_\_\_\_  
Health Care Provider's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone Number

**MEDICAL RELEASE:**

I authorize the above 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

THIS IS A CONFIDENTIAL RECORD AND IT SHALL BE MAINTAINED AS SUCH  
AS REQUIRED BY THE AMERICANS WITH DISABILITIES ACT.