

**COMAL INDEPENDENT SCHOOL DISTRICT
CERTIFICATION OF PHYSICIAN OR PRACTITIONER**
(Family and Medical Leave Act of 1993)

**Please return by fax to
Valerie Galan @
(830) 221-2152**

THIS INFORMATION REQUIRED BY LAW - TO BE COMPLETED BY MEDICAL PROVIDER

Please type or print

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|---|---|
| 1. Name of employee (First Name, Middle Initial, Last Name) | 1. Patient's name (If other than employee) (for a family member please complete BOTH sides) |
| 3. A "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves one of the conditions listed below. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category. (Here and elsewhere on this form the information sought relates only to the condition for which the employee is taking FMLA leave.) | |
| <p><input type="checkbox"/> (1) Hospital Care - Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity* or subsequent treatment in connection with, or consequent to, such inpatient care.</p> <p><input type="checkbox"/> (2) Absence Plus Treatment - A period of incapacity* of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:</p> <p style="margin-left: 20px;">(a) Treatment** two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or</p> <p style="margin-left: 20px;">(b) Treatment by a health care provider on at least one occasion which results in a regime of continuing treatment* under the supervision of the health care provider.</p> <p><input type="checkbox"/> (3) Pregnancy - Any period of incapacity due to pregnancy or prenatal care.</p> <p><input type="checkbox"/> (4) Chronic Condition Requiring Treatment - A chronic condition which:</p> <p style="margin-left: 20px;">(a) Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;</p> <p style="margin-left: 20px;">(b) Continues over an extended period of time (including recurring episodes of a single underlying condition); and</p> <p style="margin-left: 20px;">(c) May cause episodic rather than a continuing period of incapacity* (e.g., asthma, diabetes, epilepsy, etc.)</p> <p><input type="checkbox"/> (5) Permanent/Long-term Conditions Requiring Supervision - A period of incapacity* which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.</p> <p><input type="checkbox"/> (6) Multiple Treatments (Non-Chronic Conditions) - Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity** or more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), and kidney disease (dialysis).</p> | |
| 4. State the approximate date the condition commenced. | 5. Probable duration of condition or approximate return to work date. If for pregnancy, state EDC and approximate length of postnatal care. |
| 6. Regimen of treatment to be prescribed (indicate number of visits, general nature and duration of treatment, including referral to other providers of health services). | |
| <p>a. By physician or practitioner:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div> <p>b. If by another provider of health services, please state name of practitioner and the nature of the treatment:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div> | |
| 7. Will it be necessary for the employee to work only intermittently or on a less than full schedule as a result of the condition (including for treatment described in Item 6 above)? | |
| Approximate number and duration of treatments: <input style="width: 50%;" type="text"/> | |
| 8. Check "Yes" or "No" in appropriate box. | |
| <p>a. Is the employee able to perform work of any kind? <input type="radio"/> Yes <input type="radio"/> No</p> <p>b. If able to perform some work, is the employee able to perform any one or more of the essential functions of the employee's job? (Answer after discussing with employee or employer.) <input type="radio"/> Yes <input type="radio"/> No</p> | |
| PLEASE SIGN ON REVERSE SIDE | |
| * ** *** Please see reverse side. | |

INFORMATION TO BE COMPLETED BY PHYSICIAN OF FAMILY MEMBER ONLY:

Check "Yes" or "No" in appropriate box.

1. Yes No Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?

Check "Yes" or "No" in appropriate box.

2. Yes No After review of the employee's signed statement (See Item 4 below), is the employee's presence necessary or would it be beneficial for the care of the patient? (This may include psychological comfort.)

3. Estimate the period of time care is needed or if the employee's presence would be beneficial:

EMPLOYEE

ITEM 4 IS TO BE COMPLETED BY THE EMPLOYEE NEEDING FAMILY LEAVE:

4. When family leave is needed to care for a seriously-ill family member, the employee shall state the care he or she will provide and an estimate of the time period during which this care will be provided. A schedule must be included if leave is to be taken intermittently or on a reduced leave schedule.

Employee Signature

Date

PHYSICIAN'S SIGNATURE

THE FOLLOWING INFORMATION MUST BE COMPLETED ON ALL FORMS

4. _____
Signature of physician or practitioner
- _____
Address
- _____
Type of Practice (Field of Specialization, if any)
- _____
Name of physician or practitioner (PLEASE PRINT)
- _____
Phone Number
- _____
Date

FMLA Definitions

- * "Incapacity" for purposes of FMLA is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.
- ** "Treatment" includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations or dental examinations.
- *** "A regimen of continuing treatment" includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment. A regimen of treatment does not include taking over-the-counter medications such as antihistamines or aspirin; or bedrest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

Print Form

SAMPLE GINA DISCLOSURE NOTICE

Attach to all medical certification forms or requests for medical information.

Date: _____

To: Healthcare Provider
_____ *(Employee)*

From: _____
_____ ISD

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.