BRILLION SCHOOL DISTRICT
POLICY 532.31
Form B.1 General

Family and Medical Leave Request Health Care Provider Certification

I, _____, state that _____
(Name of Health Care Provider) (Patient's Name)

is under my care for an illness or injury, impairment, or physical or mental condition involving (check the appropriate box):

- ☐ Inpatient care in a hospital, hospice, or residential medical facility; and/or
- ☐ Period of incapacity requiring:
  - Absence from work, school, or other regular activities;
  - For more than three (3) calendar days; **and**
  - Involving continuing treatment or supervision by a health care provider during such period of time;
- ☐ Continuing treatment by (or under the supervision of) a health care provider for a chronic or long-term health condition that is incurable or so serious that it may result in a period of incapacity of more than three (3) calendar days; or
- ☐ Prenatal care.

In addition, I certify that the patient is one of the following (Check the appropriate box):

- ☐ An employee of the Brillion School District;
- ☐ The spouse of an employee;
- ☐ The son or daughter of an employee;
- ☐ The parent of an employee.
- ☐ The parent-in-law of an employee.

Accordingly, I certify that:

- The health condition commenced on _____, 20____ and has a probable duration through _____, 20_____.

- The patient was first seen by me relative to, and treated for, this serious health condition on _____.

- I have provided care to the patient on the following date(s). (List all dates of treatment or supervision):
  _____

- The patient was treated on an inpatient/outpatient basis (circle which is applicable).

- The medical facts regarding the serious health condition are as follows, including the notice of the condition:

  _____

<u>If the patient is an employee:</u> the serious health condition must render the employee unable to perform the functions of his or her position which means the employee is unable to work at all or unable to perform the essential functions of the position. Attached is a Job Description of the position of the employee.

- I have read the employee's job description and am aware of the job functions required for this employee to perform the functions of the position. The following functions may be performed by the employee:

Yes	No	
☐	☐	Standing for 30 minutes or less
☐	☐	Standing for more than 30 minutes, but less than 2 hours (with or without breaks)
☐	☐	Standing for more than 2 hours (with or without breaks)
☐	☐	Sitting for 30 minutes or less
☐	☐	Sitting for more than 30 minutes, but less than 2 hours (with or without breaks)
☐	☐	Sitting for more than 2 hours (with or without breaks)

☐ ☐ Walking short distances (20 yards)

☐ ☐ Arm movement (if limited please note below)

☐ ☐ Talking

- Below is an explanation of the extent to which the employee is unable to perform the functions of the position as a result of the health condition.

_____
_____

_____

- If the employee requires intermittent (leave taken in blocks of time) or reduced leave (leave that reduces the employee's hours per workweek or workday) which is medically necessary, please describe why the intermittent or reduced leave is medically necessary, the dates on which treatment is expected, and the expected duration of the treatment and leave.

_____

_____

_____

- Was the procedure/treatment scheduled in advance or on an emergency basis? If scheduled in advance, please indicate how many days in advance the treatment was scheduled.

Scheduled in advance □ Emergency Basis □
Date Scheduled: _____
Comments, if any: _____

<u>If the patient is the spouse, son, daughter, parent, or parent-in-law of the employee ("Family Member"):</u> the serious health condition of such individual must require that the employee is needed to care for such individual. A serious health condition for such individual is any condition that affects an individual's ability to engage in normal daily activities.

- The employee will be needed to care for the Family Member for approximately the following length of time: _____

- Describe care to be provided by employee: _____

_____

- If the employee requires intermittent (leave taken in blocks of time) or reduced leave (leave that reduces the employee's hours per workweek or workday) to care for the Family Member, please describe why it is necessary, the schedule of treatment and the duration.

  _____

  _____

  _____

Dated this _____ day of _____, 20 _____.

_____ _____

Signature of Health Care Provider Telephone Number

_____ _____

Address City/State

Reviewed: 7/20/09