

**Certification of Health Care Provider for Employee's Serious Health Condition  
Family and Medical Leave Act**

**SECTION I: For Completion by the EMPLOYER**

Company Name: Nebraska Department of Education		Date:
Contact Name: Amy Spellman	Contact Phone: 402-471-5027	Contact Fax: 402-471-6639
Employee's Name:		
Employee's Job Title:		
Employee's Regular Work Schedule: From:      AM/PM To:      AM/PM <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> T <input type="checkbox"/> F <input type="checkbox"/> S		
Employee's Essential Job Functions, or see attached job description. <input type="checkbox"/> Check if job description is attached.		

**SECTION II: For Completion by the EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II before giving this form to your medical provider. You are required to submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. Your response is required to obtain or retain the benefit of FMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. **You have 15 calendar days to return this form.**

First Name:	Middle Name:	Last Name:
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**SECTION III: For Completion by the HEALTH CARE PROVIDER**

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer 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 FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. The **Genetic Information Nondiscrimination Act (GINA) Title II** prohibits employers from requesting or requiring genetic information of employees or their family members. In order 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 test, 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. Please be sure to sign the form on the last page.

Provider's Name:	
Provider's Business Address:	
Type of Practice/Medical Specialty:	
Phone #:	Fax #:

**PART A: MEDICAL FACTS**

1. Approximate date condition commenced:	Probable duration of condition:
Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? <input type="checkbox"/> No <input type="checkbox"/> Yes	
If yes, dates of admission:	
Dates you treated patient for condition:	
Will the patient need to have treatment visits at least twice per year due to the condition? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Was medication, other than over-the-counter medication, prescribed? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Was patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? <input type="checkbox"/> No <input type="checkbox"/> Yes	
If so, state the nature of such treatments and expected duration of treatment:	

2. Is the medical condition pregnancy?  No  Yes If so, expected delivery date:

3. Use the information provided by the employer in Section I to answer this question. *If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.*

Is the employee unable to perform any of his/her job functions due to the condition:  No  Yes

If so, identify the job functions the employee is unable to perform:

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

**PART B: AMOUNT OF LEAVE NEEDED**

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery?  No  Yes

If so, estimate the beginning and ending dates for the period of incapacity:

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition?  No  Yes

If so, are the treatments or the reduced number of hours of work medically necessary?  No  Yes

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: Date: Amt. of Time: Date: Amt. of Time: Date: Amt. of Time:	Estimate the part-time or reduced work schedule the employee needs, if any: # Hour(s) per day: # Days per week: From: Through:
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7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions?  No  Yes

Is it medically necessary for the employee to be absent from work during the flare-ups?  No  Yes

If so, explain:

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

**Frequency:** times per:  Week(s)  Month(s)      **Duration:** hours or day(s) per episode

**ADDITIONAL INFORMATION: (Identify question number with your additional answer.)**

**Signature of Health Care Provider:** \_\_\_\_\_ **Date:** \_\_\_\_\_