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Complete this form and fax it to: Canyons School District-Human Resources ATTN: Ken Anderson, 801-826-5374

SECTION I: For Completion by the EMPLOYEE

The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

First	Middle	Last
Employee's job title:		Work Schedule:
Provider's name and business address:		
Type of practice / Medical specialty:		
Telephone: ()	Fax :()

SECTION II: 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. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

Be sure to sign the form on the last page.

PART A: MEDICAL FACTS OF PATIENT

Approximate date condition began:					
Probable duration of condition: Mark as applicable:					
If yes, list date(s) of admission:					
Date(s) patient was treated for condition:					
Will the patient need to have treatment visits at least twice per year due to the condition? NO YES					
Will medication, other than over-the-counter medication, prescribed? NO YES					
Was the patient referred to other health care provider(s) for evaluation or treatment? (e.g., physical therapist)? NO YES					
If yes, state the nature of such treatments and expected duration of treatment:					
Is the medical condition pregnancy? No Yes. If yes, list the expected delivery date:					
<u>Use the information provided by the employer in Section I to answer this question.</u> 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 yes, identify the job functions the employee is unable to perform:					
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

ADDIT	IONAL I	NFORMATION: List question number you need to expand upon
Fr _	equency	of condition:
fre	quency o	pon the patient's medical history and your knowledge of the medical condition, estimate the of flare-ups and the duration of related incapacity that the patient may have over the next 6 g., 1 episode every 3 months lasting 1-2 days)
	job resp Is it me	condition cause episodic flare-ups periodically preventing the employee from performing his/her consibilities? YES NO dically necessary for the employee to be absent from work during the flare ups? YES NO If yes, explain:
	C.	Estimate the part-time/reduced work schedule the employee needs while being treated, if applicable: Hours per day days per week Date Time Frame:
2.	becaus a.	employee need to attend follow up treatment appointment or work part-time/on a reduced schedule to of the employee's condition? YES NO If yes, are the treatments or the reduced number of hours of work medically necessary? Yes No If yes, list and estimated treatment schedule, if any, and include the dates of schedule appointments and time request for each appointment/recovery period:
1.	includir	eemployee be incapacitated for a single continuous period of time, due to his/her medical condition, and time for treatment and recovery? YES NO If yes, estimate the beginning and ending dates for the period of incapacity:

Signature of Health Care Provider	Date

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29

C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210.

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.