826 South 1500 East
Naples, UT 84078
(435) 781-3100

CERTIFICATION OF HEALTH CARE PROVIDER

(PLEASE CHECK ALL THAT APPLY)

☐ **FAMILY AND MEDICAL LEAVE ACT AND SICK LEAVE BANK**
☐ **FAMILY AND MEDICLAL LEAVE ACT WITHOUT SICK BANK**

For consideration of Sick Leave Bank days, employee must also submit completed Uintah School District Sick Leave Bank Application Form and Authorization for use and Disclosure of Health Information Form

Employee's Name: _____

Patient's Name (if different from employee):_____

I hereby grant permission for my doctor to provide Uintah School District with information regarding my medical condition.

Employee/Patient Signature: _____

TO BE COMPLETED BY HEALTH CARE PROVIDER:

****If this is an elective surgery, can the surgery be scheduled after June 1 during the employee's summer break? Please give details.**

_____
_____
_____

1. The attached sheet describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition (for which s/he 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____

2. 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:_____
_____
_____
_____

3 a. State the approximate date the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present incapacity - or inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment for it, or recovery from it - if different;):

_____
_____
_____
_____

b. Will it be necessary for the employee to take work only intermittently or to work on a less than full schedule as a result of the condition (including for treatment described in Item 6 below)?

_____

If yes, give the probable duration:_____
_____

c. If the condition is a chronic condition (condition #4) or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity:

_____
_____

4 a. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments:

_____
_____

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:

_____
_____
_____

b. 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:

_____
_____
_____

c. 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:

_____
_____
_____
_____

5 a. If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind? _____

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 employer should supply you with information about the essential job functions)?_____ If yes, please list the essential functions the employee is unable to perform:

_____

_____
_____
_____

c. If neither a. nor b. applies, is it necessary for the employee to be absent from work for treatment?

_____
_____

d. **Restrictions:**

Task		**Restricted to:**	**Restricted to:**	**Restricted to:**	**Other: (please list)**
Standing	No restrictions	1-4 hours	4-6 hours	6-8 hours	
Sitting	No restrictions	1-4 hours	4-6 hours	6-8 hours	
Walking	No restrictions	1-4 hours	4-6 hours	6-8 hours	
Lifting	No restrictions	0-10 lbs	10-20 lbs	20-30 lbs	30-40 lbs
Driving	No restrictions	1-4 hours	4-6 hours	6-8 hours	
May use hands for repetitive motion of:	No restrictions	Single grasping	Pushing/ Pulling	Fine manipulation	
Bending	No restrictions	1-4 hours	4-6 hours	6-8 hours	
Stooping	No restrictions	1-4 hours	4-6 hours	6-8 hours	
Twisting	No restrictions	1-4 hours	4-6 hours	6-8 hours	
Climbing	No restrictions	1-4 hours	4-6 hours	6-8 hours	
Squatting	No restrictions	1-4 hours	4-6 hours	6-8 hours	
Kneeling	No restrictions	1-4 hours	4-6 hours	6-8 hours	
Limited repetitive motion	No restrictions	1-4 hours	4-6 hours	6-8 hours	
Limited work around machinery	No restrictions	1-4 hours	4-6 hours	6-8 hours	
Any other restrictions? Please list					

- Estimated return to work date with no restrictions: _____
- Next scheduled medical appointment: _____
- Referred for additional care to:
    - **Doctor's Name:** _____
    - **Appointment Date:** _____

6 a. If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation?

_____
_____

b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery?_____
_____

c. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need:
_____
_____

Heath Care Providers Signature:

_____ _____

(Signature of Health Care Provider) (Type of Practice)

_____

(Address) (City/State) (Telephone Number)

To be completed by the employee needing family leave to care for a family member:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

_____
_____
_____

Employee Signature:

_____ _____

(Employee Signature) (Date)

Definitions of "Serious Health Condition" for line 3 of the Certificate of Health Care Provider form.

A "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. Hospital Care

   Impatient 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.

2. Absence Plus Treatment

   (a) 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:

      (1) Treatment (includes examinations to determine if a serious health condition exists and evaluation of the condition; treatment does not include routine physical examinations, eye examinations, or dental examinations) 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*

      (2) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment (includes, for example, a course of prescription medication such as antibiotic or therapy requiring special equipment to resolve or alleviate the health condition; does not include the taking of over-the-counter medication such as aspirin, antihistamines, or salves, bedrest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider) under the supervision of the health care provider.

3. Pregnancy

   Any period of incapacity due to pregnancy, or for prenatal care.

4. Chronic Conditions Requiring Treatments

   A chronic condition which:

      (1) Requires period visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;

      (2) Continues over an extended period of time (including recurring episodes of a single underlying condition); and

      (3) May cause episodes rather than a continuing period of incapacity, *e.g.*, asthma, diabetes, epilepsy, etc.

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.

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 of restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy, kidney disease (dialysis).