NORTH EAST INDEPENDENT SCHOOL DISTRICT
Medical Certification

A complete medical certification is required to determine whether your health condition, or the health condition of your Spouse, Child (under the age of 18) or Parent, qualifies for leave under the Family Medical Leave Act (FMLA) regulations.

Instructions to Employee: Complete Sections I and III. If you are requesting leave to care for your Spouse, Child (under the age of 18) or Parent who has a serious health condition, complete Section II as well. Your health care provider or your family member's health care provider must complete Sections IV through VII. **It is your responsibility to ensure the health care provider completes and returns these forms to the appropriate address or fax number provided below within 15 calendar days from the date of your request.**

Instructions to Health Care Provider: Your patient, or a family member of your patient, has requested a Leave of Absence. In order for us to verify whether this qualifies under the FMLA, you must complete Sections IV through VII (page 2) of these forms.

Important Notice Regarding GINA: 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.

Sections I through III: For completion by the Employee

Section I – Patient Information (Print)

Employee's Name: _____

Employee's: Phone Number: _____

Employee's Mailing Address: _____

Section II – Care for Family Member (Print)

Patient's Name: _____

Relationship to Employee: _____ If child, provide date of birth: _____/_____/_____

Section III – Employee Signature

I authorize the North East Independent School District Office of Human Resources or its designated health care provider/third party administrator to contact my health care provider or my family member's health care provider for purposes of obtaining clarifying information and authenticity of the medical certification, if necessary.

_____ _____/_____/_____

Employee Signature Date

Return to Leave Management Specialist | Human Resources | North East ISD
8961 Tesoro Drive, Suite 200 | San Antonio, Texas 78217
Fax: (210) 805-2767 | leaveofabsence@neisd.net
Michele Matheny (A-L) (210) 407—0497 | Emiley Aragon (M-Z) (210) 407-0469

Sections IV though VII: For completion by the Health Care Provider

Section IV – Patient Information (Print)

1. Employee's Name: _____
2. Patient's Name: _____
3. Patient's relationship to the employee (check one): ☐ Self ☐ Spouse ☐ Child (under the age of 18) ☐ Parent

Section V – Designation of Serious Health Condition (Print)

4. Does the patient's condition for which leave is being requested qualify as a Serious Health Condition? A "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves inpatient care or continuing treatment by a health care provider.

   ☐ Yes ☐ No (proceed to Section VII)

Section VI – Duration of Incapacity and Treatments (Print)

5. Indicate relevant medical facts
   (i.e. symptoms, diagnosis, regimen of treatment):

   _____

   _____

6. State the approximate date the condition commenced:

   _____/_____/_____

7. Estimate the probable duration of condition:

   _____/_____/_____ to _____/_____/_____

8. Will the patient be incapacitated for more than three consecutive days due to the medical condition? "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition.

   ☐ Yes ☐ No

   If yes, please estimate beginning and ending dates.

   _____/_____/_____ to _____/_____/_____

9. Due to the condition, was the patient referred to another health care provider for evaluation or treatment (i.e., physical therapist)?

   ☐ Yes ☐ No

   If yes, please state the nature of such treatments and expected frequency and durations of treatment:

   _____

   _____

Section VI (Continued)

10. Due to the condition, will it be medically necessary to attend follow-up treatments/appointments? ☐ Yes ☐ No

    If yes, please estimate treatment schedule or appointments

    Frequency: _____ times per: ☐ Week ☐ Month ☐ Year

    Duration: _____ hours OR _____ day(s) per appointment

11. If condition causes episodic flare-ups during these periods, will it be necessary for the patient to be absent from work?

    ☐ Yes ☐ No

    If yes, please provide the estimated:

    Frequency: _____ times per:

    ☐ Day ☐ Week ☐ Month ☐ Year

    Duration: _____ hours OR _____ day(s) per episode

12. Due to the condition, will it be medically necessary to be on a reduced work schedule? ☐ Yes ☐ No

    If yes, please explain what the reduced work schedule will look like:_____

    _____

    _____

13. Additional Information:

    _____

    _____

Section VII – Physician Information

Name of Health Care Provider (Print): _____ Provider's Signature: _____

Type of Practice: _____ Address: _____

Telephone Number:_____ Fax Number: _____ Date: _____/_____/_____

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