KENNEWICK SCHOOL DISTRICT

Human Resources Office
1000 West Fourth Avenue, Kennewick, WA 99336-5601 (509) 222-5010 FAX (509) 222-5051

CERTIFICATION OF HEALTH CARE PROVIDER

(for Family and Medical Leave Act of 1993)

TO: Health Care Provider
FROM: Kennewick School District Human Resources Office
SUBJECT: **Request for Family and Medical Leave or Leave Sharing for Kennewick School District Employee**

The employee as stated below has requested Family Medical Leave and/or Leave Sharing from their employment with Kennewick School District.

Employee's Signature for Release of Information to Kennewick School District:

_____

Employee Signature **Date**

Please complete the following information to assist us in reviewing employee's eligibility for this program.

PLEASE ANSWER EACH QUESTION IN THIS SECTION:

1. Employee's Name (please print) _____
2. Patient's Name (if other than employee) _____
   Relationship to employee _____

3. The attached sheet describes what is meant by a "**serious health condition**" under the Family and Medical Leave Act. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category.
   (1)_____ (2)_____ (3)_____ (4)_____ (5) _____ (6)_____None of the these _____

4. 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.
   _____

   _____

5. State the approximate date the condition commenced, and the probable duration of the condition. State the probable duration of the patient's present incapacity, if different than condition stated.
   _____

PLEASE COMPLETE THIS SECTION FOR EMPLOYEE'S HEALTH CONDITION:

6. Will it be necessary for the employee to be absent from work, work intermittently, or work less than a full schedule as a result of the condition? Absent from work _____ Work intermittently _____ Work less than full schedule _____
   If one of the above is checked, give the probable duration. _____

   If the condition is a chronic condition (#4 of attached sheet) or pregnancy, state whether the patient is presently incapacitated (defined as "inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom") and the likely duration and frequency of episodes of incapacity.
   _____

   _____

   (a) If additional treatment will be required for the condition, provide an estimate of the probable number of such treatments.
   _____

(continued – over)

6. (b) If the patient will be absent from work or other daily activities because of treatment on an intermittent or part-time basis, 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.

_____

7. 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?
Yes _____ No _____

(a) If able to perform some work, is the employee unable to perform the essential functions of his/her job?
Yes _____ No _____

(b) 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?
Yes _____ No _____

PLEASE COMPLETE THIS SECTION FOR EMPLOYEE'S FAMILY MEMBER'S HEALTH CONDITION:

8. If leave is required to care for a family member with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation for medical reasons?
Yes _____ No _____

(a) If no, would the employee's presence provide psychological support to assist in the patient's recovery?
Yes _____ No _____

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

PLEASE COMPLETE ALL INFORMATION BELOW:

9. State the care you will be providing the patient and the estimate of the period during which care will be provided.
Care to be provided: _____

Estimate of Time Period: Commence _____ End _____

This information has been provided to the best of my knowledge.

_____ _____
Signature of Health Care Provider Printed Name of Health Care Provider

_____ _____
Type of Practice Telephone Number with area code

_____, 20 _____ _____
Date Address

To be completed by the employee needing family care 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 **Date**

Please return completed form to:
Human Resources Office
Kennewick School District, 1000 West Fourth Avenue, Kennewick, Washington 99336-5601 **FAX # (509)222-5051**

KENNEWICK SCHOOL DISTRICT

Attachment (a) to Form "CERTIFICATION OF HEALTH CARE PROVIDER"

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

1) **Hospital Care** – Inpatient care (i.e. 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 period of incapacity of more than three consecutive calendar days that also involves:
   a) Treatment two or more times by a health care provider or
   b) Treatment on at least one occasion by a health care provider which results in a regimen of continuing treatment under the health care provider's supervision. (This does not include treatment which can be initiated by patient without a visit to the health care provider.)

3) **Pregnancy** – Any period of incapacity due to pregnancy or for prenatal care.

4) **Chronic Condition Requiring Treatments** – A chronic condition which:
   a) Requires periodic visits for treatment by a health care provider
   b) Continues over an extended period of time
   c) May cause episodic rather than continuing period of incapacity (asthma, 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, but that the employee or family member is under the continuing supervision of a health care provider.

6) **Multiple Treatments (non-chronic)** – Any period of absence to receive multiple treatments (including period of recovery) by a health care provider for restorative surgery after an accident of injury, or a condition that would result in a period of incapacity of employee/family member in the absence of medical intervention or treatment.