CITY OF BRYAN
The Good Life, Texas Style.

CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS HEALTH CONDITION

(Family and Medical Leave Act)

SECTION I: EMPLOYER

Employer Name and Contact: City of Bryan –Teresa McGinnis, HR Generalist

979-209-5063 (Phone), 979-209-5059 (Fax) or tmcginnis@bryantx.gov (Email)

SECTION II: To be completed by EMPLOYEE

Please complete this section before giving the form to your health care provider. 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 the denial of your FMLA request. Your employer must give you at least 15 calendar days to return this form.

Employee Name (First Middle Last): _____

Employee's Job Title: _____ **Regular Work Schedule**: _____

SECTION III: To be completed by HEALTH CARE PROVIDER ONLY

Instructions to the Health Care Provider: Your patient has requested leave under the FMLA. Please answer, fully and completely, all applicable parts. Your answer should be your best estimate based upon your medical knowledge and experience. "Unknown" or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Failure to provide sufficient information may cause the employee's FMLA request to be delayed or denied. Please be sure to sign the form on the last page.

GINA Notification to the Health Care Provider: Do not provide information about genetic tests, genetic services, or the manifestation of disease or disorder in the employee's family members.

PART A: MEDICAL FACTS

Approximate date condition began: _____ Probable duration: _____

Date(s) you treated the patient for condition: _____

1. Describe medical facts such as symptoms, diagnosis, or any regimen of continuing treatment related to the condition for which the employee seeks leave: _____

   _____

   _____

2. Based on the employee's description of his/her job functions, is he/she unable to perform their job due to this condition?

   ☐ No ☐ Yes If yes, identify functions unable to perform: _____

   _____

3. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

   ☐ No ☐ Yes If yes, dates of admission: _____

4. Will the patient need to have treatments/visits at least twice per year due to the condition? ☐ No ☐ Yes

5. Was medication, other than over-the-counter medication, prescribed? ☐ No ☐ Yes

6. 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 and expected duration of treatment: _____

7. Is the medical condition pregnancy? ☐ No ☐ Yes If yes, expected delivery date: _____

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PART B: AMOUNT OF LEAVE NEEDED

1. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition?

   ☐ No ☐ Yes If yes, beginning and ending dates: _____

2. Will the employee need to work a part-time or reduced work schedule, or attend follow-up treatments?

   ☐ No ☐ Yes If yes, please estimate:

   _____ Hour(s) per day; _____ Day(s) per week From (date) _____ through (date) _____

3. Will the employee have episodic flare-ups preventing him/her from performing his/her job functions?

   ☐ No ☐ Yes If yes, estimate the frequency and duration over the next 6 months (e.g. 1 episode every 3 months lasting 1-2 days):

   Frequency: _____ number of episodes every _____ ☐ week(s) or ☐ month(s)

   Duration: _____ hour(s) or _____ day(s) per episode

   From (date) _____ through (date) _____

PART C: RETURN TO WORK

The employee's current health condition, for which he/she is being treated,

☐ Will allow the employee to return to work as of _____ (date) **without** restrictions.

☐ Will allow the employee to return to work as of _____ (date) **with** restrictions as **identified below,** which are expected to last through _____ (date).

_____

_____

_____

ADDITIONAL INFORMATION

_____

_____

_____

Provider's Name and Business Address: _____

Type of Practice / Medical Specialty: _____

Telephone: _____ **Fax**: _____

_____ **Date:** _____

Signature of Health Care Provider

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*DETAILED ACTIVITY RESTRICTIONS

To be completed by health care provider **only** if detailed restrictions apply to employee returning to work.

POSTURE RESTRICTIONS (if any):							
Max Hours Per Day:	**0**	**2**	**4**	**6**	**8**	**Other**	
Standing							
Sitting							
Kneeling/Squatting							
Bending/Stooping							
Pushing/Pulling							
Twisting							
Other: _____							

MOTION RESTRICTIONS (if any):							
Max Hours Per Day:	**0**	**2**	**4**	**6**	**8**	**Other**	
Walking							
Climbing stairs/ladders							
Grasping/Squeezing							
Wrist Flexion/Extension							
Reaching							
Overhead Reaching							
Keyboarding							
Other:							

√	LIFT/CARRY RESTRICTIONS (if any):
	May not lift/carry objects more than_____lbs. for more than _____ hours per day.
	May not perform any lifting/carrying.
	Other:

√	MISC. RESTRICTIONS (if any):
	Max hours per day of work:
	No driving/operating heavy equipment
	Can only drive automatic transmission
	No running
	Sit/stretch breaks of per
	Must wear splint/cast at work
	Must use crutches at all times
	Must keep elevated and/or clean & dry
	Dressing changes necessary at work
	No skin contact with:
	No work for hours/day's work:
	____in extreme hot/cold environments
	____at heights or on scaffolding

√	RESTRICTIONS SPECIFIC TO (if applicable):		
	Left Hand/Wrist		Right Hand/Wrist
	Left Arm		Right Arm
	Left Leg		Right Leg
	Left Foot/Ankle		Right Foot/Ankle
	Neck		Back
	Other:		

√	MEDICATION RESTRICTIONS (if any):	OTHER RESTRICTIONS (if any):
	Must take prescription medication(s)	
	Advised to take over-the-counter medication(s)	
	Meds may make drowsy (possible safety/driving issues)	

**These restrictions are based on the physician's best understanding of the employee's essential job functions. If a particular restriction does not apply, it should be disregarded. If modified duty that meets these restrictions is not available, the employee should be considered to be off work. These restrictions should apply to outside of work as well as at work.*

Provider's Name and Business Address: _____

Type of Practice / Medical Specialty: _____

Telephone: _____ **Fax**: _____

_____ **Date**: _____

Signature of Health Care Provider