Certification of Health Care Provider for Employee's Serious Health Condition Family and Medical Leave (FML)

TO BE COMPLETED BY THE EMPLOYER

INSTRUCTIONS TO THE EMPLOYER: The Navajo Nation Personnel Policy Manual (NNPPM) Section X.D. provides that an employer may require an employee seeking FML protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete this section before giving this form to your employee. The Department of Personnel Management maintains records and documents relating to medical certifications and re-certifications of employees for FML purposes as confidential medical records in a separate file.

Employer name and contact:_____

Employee's job title:_____ Regular work schedule:_____

Employee's essential job functions:_____

_____

Check if job description is attached: ☐

TO BE COMPLETED BY THE EMPLOYEE

INSTRUCTIONS TO THE EMPLOYEE: Please complete this section before giving this form to your medical provider. The FML permits an employer to require that you submit a timely, complete and sufficient medical certification to support your request for FML due to your own serious health condition. Your employer must give you at least 15 calendar days to return this form.

Employee name: _____
(First) (Middle) (Last)

TO BE COMPLETED BY THE HEALTH CARE PROVIDER

INSTRUCTIONS TO THE HEALTH CARE PROVIDER: Your patient has requested leave under the FML. Please answer, fully and completely all applicable parts. Several questions seek a response as to the duration of a condition, treatment, etc. Be as specific as you can. Limit your response to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's name and business address:_____

Type of practice/Medical specialty:_____

Telephone: (____)_____ Fax: (____)_____

PART A: Medical Facts

1. Approximate date condition commenced:_____

   Probable duration of condition:_____

   Mark Below as applicable:
   Was the patient admitted for an overnight stay in a hospital, hospices or residential medical care facility?
   No ☐ Yes ☐ If so, dates of admission: _____

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

   Will the patient need to have treatment visits at least twice per years due to the condition? No ☐ Yes ☐

   Was 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 so, state the nature of such treatments and expected duration of treatment:

   _____

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

3. Use the information provided by the employer on Page 1 to answer this question. 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 so, identify the job functions the employee is unable to perform:

   _____

4. 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

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical certification, including any time for treatment and recovery? No ☐ Yes ☐

   If so, estimate the beginning and ending dates for the period of incapacity:_____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? No ☐ Yes ☐

   If so, are the treatments or the reduced number of hours of work medically necessary? No ☐ Yes ☐

   Estimate treatments schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   _____

   Estimate the part-time or reduced work schedule the employee needs, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

ADDITIONAL INFORMATION: Identify question number with your additional answer:

_____

_____

_____

_____

_____

_____

_____

_____

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_____ _____

Signature of Health Care Provider Date