Scio School District 95

Code: **GCBDA/GDBDA-AR(3)(B)**
Revised/Reviewed: 10/21/09; 9/18/13; 12/13/17
Orig. Code(s): GCBDA/GDBDA-AR(3)(B)

Certification of Health Care Provider

Family Member's Serious Health Condition

To be Completed by the District:

The Family Medical Leave Act (FMLA) provides that a district may require an employee seeking FMLA leave protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Employees may not be asked to provide more information than allowed under the FMLA regulations. The district will maintain records and documents relating to medical certification, recertifications or medical histories of the employee's family members, created for FMLA purposes, as confidential medical records in separate files from personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

District contact person: _____

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

Employee's essential job functions: _____

_____

Check if job description is attached: ☐

Return this completed form on _____ (date) (must be at least 15 days after employee is notified of this requirement).

To be Completed by the Employee:

Complete the information below before giving this form to your family member or his/her medical provider. The return of this form is required to obtain or retain the benefit for FMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request.

Employee's name: _____
First Middle Last

Relationship and name of family member for whom employee will provide care: _____
Relationship

_____
First Middle Last

If the family member is your child, please provide his/her date of birth: _____

Describe the care you will provide to your family member and estimate the leave needed to provide such care:

_____

_____

_____ _____
Employee Signature Date