Family Medical Leave Act (FMLA) Application Form

To be completed by you and a licensed health care provider describing the employee's medical condition for the purpose of determining eligibility for leave under the Family Medical Leave Act.

TO BE COMPLETED BY EMPLOYEE

I authorize my medical provider(s) _____ to complete this form based on information from my patient file and provide this form to the District 120 Human Resources Director.

First Name: _____ Middle Initial: _____ Last Name: _____

Signature: _____ Date: _____

Instructions for the Health Care Provider

Your patient is requesting leave under the Family Medical Leave Act. Please answer, fully and completely all applicable parts of this form. Several questions seek a response as to the frequency or duration of a condition, treatment plan, etc. Your answers should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Please be as specific as possible and limit your response to the condition for which the employee is seeking leave. When applicable, circle YES or NO to indicate your response.

The Genetic Information Nondiscrimination Act of 2008 prohibits employers from requesting or requiring genetic information of an 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 this law, includes an individual's family medical history, 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.

TO BE COMPLETED BY THE HEALTH CARE PROVIDER

Provider's Name: _____

Provider's Business Address: _____

Type of Practice/Medical Specialty: _____

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

When did the medical condition(s) begin?

How long is the condition expected to last? If the condition is permanent, please indicate.

Was the patient admitted for an overnight stay in a hospital or residential medical care facility? If yes, what were the dates of admission?

What were the dates in which you treated the patient for this condition?

Will the patient require treatment at least twice per year due to the condition? YES or NO

Was medication, other than over-the-counter medication prescribed? YES or NO

Was the patient referred to other health care providers for evaluation or treatment? If yes, please state the nature of the treatments and expected duration of treatment.

Is the medical condition pregnancy? YES or NO If yes, expected delivery date: _____

Has the patient provided you with their job description? YES or NO If no, please answer these questions based upon the patient's own description of their essential job functions.

Is the patient unable to perform any of their essential job functions due to the condition? YES or NO If yes, identify the job functions the employee is unable to perform.

Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave.

Will the patient be incapacitated for a single continuous period of time due to this condition, including any time for treatment and recovery? YES or NO

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

Will the patient require follow-up treatment appointments or work part-time/reduced schedule because of the condition? YES or NO If yes, are the treatments or reduced number of hours worked medically necessary? YES or NO

Please list the estimated treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Estimated part-time/reduced work schedule the employee needs, if any:

_____ hour(s) per day; _____days per week from _____ to _____

Will the condition cause episodic flare-ups periodically preventing the employee from performing their essential job functions? YES or NO

Is it medically necessary for the employee to be absent from work during the flare-ups? YES or NO If yes, please explain:

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of the flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per: _____ weeks/months for: _____ hours or _____ days per episode.

Signature of Health Care Provider: _____ Date: _____

When completed please fax this form to (847) 388-4770, with CONFIDENTIAL: ATTN D120 HR on the cover page.