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

SECTION I: A note from the IHB Railroad to the Employee

The Family and Medical Leave Act (FMLA) allows the IHB, as your employer, to require that you have your health care provider complete this form. This form is required if you need leave under the FMLA due to your serious health condition.

Employer name and contact: Indiana Harbor Belt Railroad, Mary Kay Conley (contact)

Employer's phone: 219-989-4923 **Employer's Fax:** 219-989-4967

Employee's Job Title: _____

Regular Work Schedule: _____

Employee's essential job functions: _____

_____

Check if job description is attached: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits us to require that you submit a timely, complete and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. Failure to provide a complete and sufficient medical certification may result in our denial of your FMLA request (20 CFR § 825.313.) You have 15 calendar days, or until _____ to return this form (29 CFR § 825. 305(b).

Your name: _____
First Middle Last

Your IHB ID No. _____

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience and examination of the patient. Be as specific as you can; terms such as "lifetime" "unknown" or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses 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, hospice, 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 year 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 IHB Railroad in Section I to answer this question. If we could not provide 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 the 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 condition, 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 treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? _____ No _____ Yes

Is it medically necessary for the employee to be absent from work during the flare-ups? _____ No _____ Yes If so, explain:

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

Frequency: _____ times per _____ week(s) _____ month(s)

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

ADDITONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER:

_____ **Signature of Health Care Provider**

_____ **Date**