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.
(IF MEDICATION NOT OVER THE COUNTER IS PRESCRIBED FILL OUT MD-1000 FORM)

Employer name and contact: Indiana Harbor Belt Railroad, Nicole Moore Parchem (contact)

Employer's phone: 219-989-4927 **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.)

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.
(IF MEDICATION NOT OVER THE COUNTER IS PRESCRIBED FILL OUT MD-1000 FORM)

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**

EMPLOYEE PRESCRIPTION DRUG REPORT

Employee's Information:

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
ID No: _____ Phone No: _____
Position: _____ Dept: _____

Physician's Information:

Name: _____
Address: _____
_____
City: _____ State: _____ Zip Code: _____
Phone No: _____ Fax No: _____

I authorize the above medical professional to release medical information to the IHB RR regarding my illness, injury, or work status, and additionally, authorize the IHB RR to contact the physician above for further information, if required.

_____ Date

_____ Employee's Signature

IHB PRESCRIPTION DRUG WAIVER

The above named employee is under my treatment for: _____

And has been prescribed the following medications: _____

The side effects of this/these drug(s) are: _____

[A] _____ They will have no effect on the ability to perform his/her job in a safe and effective manner.

[B] _____ The above named employee can be expected to be on this medication until: _____

_____ Date

_____ Personal Physician's Signature

IHB MEDICAL DIRECTOR'S REVIEW

[A] _____ I have reviewed the prescription recommended for the above named employee. This pharmaceutical treatment will not affect his/her performance on the job.

[B] _____ I have reviewed the pharmaceutical treatment recommended for the above named employee and feel the drug may affect his or her safe and effective job performance. I have consulted with the employee's personal physician and the following drugs are recommended as an acceptable substitute: _____

_____ Date

_____ IHB Medical Director's Signature

Return this form to the IHB Human Resources Department, 2721-161st Street, Hammond, IN 46323-1099, or fax this form to 219/989-4967.