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, Manager HR/LR (contact)
Employer's phone: 219-989-4850 **Employer's Fax:** 219-989-4967

If you have any questions regarding this form or if you need a copy of your functional job description to give to your physician, please contact HR/LR Manager at 219-989-4850

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 will be given at least 15 calendar days to return this form (29 CFR § 825.305 (b))

Your Name: _____

Your IHB ID# _____ Your Department _____

Your Job Title _____ Regular work schedule_____

Your essential job functions_____
Is job safety sensitive? _____ Yes _____ No

Your Email Address _____
(Email address to be provided for correspondence regarding your request. Failure to provide an email address may cause a delay in the processing of your request)

Description of needs/leave requested: _____
_____
_____

_____ _____
Employee Signature Date

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER:

Your patient has requested a medical leave of absence. Please answer all applicable parts fully and completely. Several questions seek a response as to the frequency and/or duration of a condiition, 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. Do not provide information about genetic tests, as defined in 29 CFR § 1635.3 (f), genetic services, as defined in 29 CFR § 1635.3 (e), or the manifestation of disease or disorder in the employee's family members, 29 CFR § 1635.3 (b). Please be sure to sign the form on the last page.

PROVIDER NAME: _____
PRACTICE/FACILITY NAME: _____
TYPE OF PRACTIVE/MEDICAL SPECIALTY _____
ADDRESS: _____
PHONE: _____ FAX: _____
EMAIL ADDRESS: _____

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? (If so,and job is safety sensitive,
_____ No _____ Yes please fill out form MD1000)

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 employee in Section I to answer this question. If you do not have a job description, answer these questions based upon the employee's own description of his/her job functions or contact us and we will provide you with one.

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:
(If you need a copy of the IHB's functional job description, please contact us. Contact info on pg. 4)

_____

_____

4. Describe all 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, including any time for treatment and recovery, for a single continuous period of time or intermittently over a period of time?

_____ Single Continuous _____ Intermittent

If single continuous, estimate the beginning and ending dates of the period of incapacity:

_____

If intermittent, estimate the expected frequency of need for time off:

_____

6. Due to the employee's medical condition, will the employee need to

_____ Attend follow up treatment appointments?
_____ Work part-time?
_____ Work on a reduced schedule?

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

Will the employee need to see a physician during the flare-ups?
_____ No _____ Yes

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 course of the next 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:

_____

_____

_____

_____

_____

If you have any questions while filling out this form or need a functional job description for the employee's position sent to you, please contact the HR/LR Manager at 219-989-4850.

If the IHB has questions regarding the information submitted on this form, please provide the contact information of a person at your office who can answer those questions.
NAME: _____
EMAIL: _____
PHONE: _____

_____ _____
Signature of Health Care Provider **Date**