CERTIFICATION OF HEALTH CARE PROVIDER FOR
FAMILY MEMBER'S SERIOUS HEALTH CONDITION (FMLA)

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

The Family and Medical Leave Act (FMLA) allows the IHB to require an employee seeking FMLA 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.

Employer name and contact: Indiana Harbor Belt Railroad, HR/LR Manager (contact)
Employer's phone: 219-989-4850 **Employer's Fax:** 219-989-4967

If you have any questions regarding this form please contact HR/LR Manager at 219-989-4850

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete all of Section II before giving this form to your family member or his/her medical provider. The IHB Railroad requires that you submit a timely, complete, sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. (29 USC §§ 2613, 2614 (c) (3). Failure to provide a complete and sufficient medical certification may result in a 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).

Your Name: _____

Your IHB ID# _____ Dept. _____ Job Title _____

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)

Name of family member for whom you will provide care _____

Relationship of family member to you _____
If son or daughter, list date of birth _____

Describe the type of care that you will provide to your family member
_____
_____
_____

Is care needed on an intermittent basis or a continuous block of time? _____

Estimate the amount of leave needed to provide care _____
_____

_____ _____
Employee Signature Date

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER:

The employee listed above has requested a leave under the FMLA to care for your patient. Answer fully and completely all applicable parts. 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 as terms such as "lifetime", "unknown" or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs care from this employee. Please be sure to sign the form on the last page.

PROVIDER NAME: _____

PRACTICE/FACILITY NAME: _____

TYPE OF PRACTICE/MEDICAL SPECIALTY _____

ADDRESS: _____

PHONE: _____ FAX: _____

PART A: MEDICAL FACTS

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:

_____

Is the medical condition pregnancy? _____No _____Yes

If so, expected delivery date: _____

Describe other relevant medical facts, if any, related to the condition for which the patient needs care (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

When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygenic, nutritional, safety transportation needs or the provision of physical or psychological care.

Will the patient 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

(a) If single continuous period of time, estimate the beginning and ending dates of incapacity:
from _____ to _____

During this time, will patient need care? _____ No _____ Yes

Explain the care needed by the patient from the employee and why such care is medically necessary:

_____
_____
_____

(b) If intermittent, estimate the beginning and ending dates of the period of incapacity along with the frequency and duration of care needed:
from _____ to _____
the patient will need care intermittently for
_____ hours per day; _____ days per week

Explain the care needed by the patient from the employee and why such care is medically necessary:

_____
_____
_____

Will the patient require follow-up treatments, including any time for recovery?

_____ 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:

_____
_____
_____

Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? _____ No _____ Yes

Will the patient need care during these flare-ups? _____ No _____ Yes
Will the patient require a doctor's care during these 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

Explain the care needed by the patient from the employee and why such care is medically necessary:

_____

_____

_____

ADDITONAL INFORMATION: PLEASE LIST ANY ADDITIONAL INFORMATION NEEDED TO CLARIFY YOUR ANSWERS OR THE LEAVE NEEDED:

_____

_____

_____

_____

If you have any questions while filling out this form 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**