CERTIFICATION OF HEALTH CARE PROVIDER FOR
FAMILY MEMBER'S SERIOUS HEALTH CONDITION (FAMILY AND MEDICAL LEAVE ACT)

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, Mary Kay Conley (contact)
Employer's phone: 219-989-4923 **Employer's Fax:** 219-989-4967

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her medical provider. The IHB Railroad requires you to 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©(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request (20.CFR § 825.313). You have 15 calendar days to return this form to the IHB. (29 CFR § 825.305.)

Your name: _____
First Middle Last

Your IHB ID No. _____

Name of family member for whom you will provide care: _____
First Middle Last

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate 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 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 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 your 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 patient needs leave. Page 3 provides space for additional information, should you need it. 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. 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 CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? _____ No _____ Yes

Estimate the beginning and ending dates for the period of incapacity:

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

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

5. 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:

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? _____ No _____ Yes

Estimate the hours the patient needs care on an intermittent basis, if any:

_____ hour(s) per day; _____ days per week

from _____ through _____

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

_____

_____

_____

_____

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? _____ 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 past 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

Does the patient need care during these flare-ups? _____ No _____ Yes

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

_____

_____

_____

_____

_____

ADDITONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER:

Signature of Health Care Provider **Date**