DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

Leave of Absence Medical Certification Form

Leave Type: **Employee**

This form must be completed for employees requesting **continuous** (without breaks) or **intermittent** (interrupted, non-continuous) leave due to the employee's own serious health condition.

Do not complete this form if requesting leave to care for a family member.

The employee must complete Section 1 only.

The medical professional must complete the following multiple sections:

- Section 2 – all Parts (for both continuous and intermittent leave requests)
- Section 3 if requesting continuous leave only
- Section 4 if requesting intermittent leave only
- Certification

Note: The medical professional must complete both Sections 3 and 4 if the request is for both continuous and intermittent leave. (E.g., if the employee requires both surgery and physical therapy, the employee may need continuous leave to recover from surgery, plus intermittent leave to attend physical therapy appointments after returning to work. For this type of request, the medical professional must complete both Sections 3 and 4.)

If you are seeing **multiple medical professionals,** then please be sure to secure a completed and signed medical certification from each medical professional who is authorizing you to take time off.

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All applicable pages of this form must be submitted and the medical certification must be signed by the attending medical professional. Failure to provide a complete and sufficient medical certification will result in the denial of your request.

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Explanation of Terms

The Family and Medical Leave Act (FMLA) provides for a job-protected absence from work for a certain period of time to employees who meet the minimum years of service and qualifying event requirements of FMLA. DCPS employees are required to follow the provisions set forth by both Federal FMLA and DC FMLA.

*NOTE: **FMLA does not provide a paid entitlement.** However, employees may be paid while on FMLA if they use any combination of paid leaves for which they are eligible, including: Paid Family Leave, Sick Leave, Annual Leave, Sick Leave Bank, Maternity/Paternity Leave Bank, Donated Leave, Short-Term Disability, and/or Long-Term Disability.

Paid Family Leave (PFL) provides eligible District Government employees with up to eight weeks of paid leave within a 12-month period for the birth or placement of a child with an employee, or to care for a family member who has a serious health condition.

*NOTE: **Paid Family Leave cannot be used for the employee's own serious health condition.** Paid Family Leave runs concurrently with FMLA (i.e., PFL does not add eight weeks to the employee's FMLA entitlement). The employee must specify on their application that they also are requesting PFL.

A **Qualifying Event** under PFL is:

- Birth of a child of the employee;
- Legal placement of a child with the employee (such as through adoption, guardianship, or foster care);
- Placement of a child with the employee for whom the employee assumes and discharges parental responsibilities; or
- Care of an employee's family member who has a serious health condition.

Extended Leave (EL) provides non-job protected leave to employees who wish to request leave under FMLA (Federal/DC) but are ineligible for the following reasons:

- Employee does not meet the minimum time in service requirement (worked at least 1,000 hours under Federal FMLA and at least 1,250 hours under DC FMLA within the last 12 months)
- Employee has exhausted the maximum length of leave of absence time allowed

A **Serious Health Condition**, under DC FMLA, is an illness, injury, impairment, or physical or mental condition that involves one of the following:

(1) Inpatient Care – a medical or mental health condition when it involves inpatient treatment of one or more nights in a hospital, hospice, or residential health care facility (e.g., an overnight stay)

(2) Incapacity – a period of incapacitation of three or more days

(3) Pregnancy or Prenatal Care – incapacity due to pregnancy and prenatal care

(4) Chronic Serious Health Condition – incapacitation or treatment for incapacitation from a chronic serious health condition which

- Requires periodic visits ("periodic visits" means at least two visits per year under the supervision of a healthcare provider);
- Continues over an extended period of time (this includes recurring episodes of a single underlying condition); and
- May cause episodic incapacity (such as asthma, diabetes, and epilepsy)

Explanation of Terms
(continued)

(5) Treatment Related to an Incapacity – treatments following an incapacitation of three or more days if

- Two or more treatments are required;
- The first treatment occurs within ten days of the incapacity; and
- The subsequent treatments occur within 30 days of the incapacity.

(6) Treatment to Prevent Incapacity – any period of absence to receive multiple treatments under order by a healthcare provider (including recovery time), if the treatments are for a condition that would likely result in incapacity of three or more days, absent the treatment

(7) Restorative Surgery Following an Injury – a serious health condition related to an accident or other injury (plastic and other elective surgeries are excluded)

SECTION 1: For Completion by **EMPLOYEE**

Employee name:

_____

First Middle Last

School site/work location (or sites/work locations, if applicable): _____

SECTION 2: For Completion By **PHYSICIAN**

PART A:
Medical Facts

1. Under DC FMLA, the patient's medical condition must fall under a category identified as a "serious health condition" under the Explanation of Terms on **pages 2 and 3.** Please identify the category by noting (1) through (7) to correspond to the applicable serious health condition:

   _____ (indicate (1) through (7))

2. Describe other relevant medical facts which support your certification of the serious health condition identified above. (Note: such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment -- add additional sheets, if necessary):

   _____

   _____

   _____

   _____

   _____

PART B:
Amount of Leave Requested

Please indicate the requested start and end date of the leave for the serious health condition identified above in **Part A: Medical Facts**.

Leave Start Date: _____
mm / dd / yyyy

Leave End Date: _____
mm / dd / yyyy

SECTION 2: For Completion By **PHYSICIAN**
(continued)

PART C:
Performance of Job Functions

Complete this section to certify the employee's fitness to perform the essential functions of the job once s/he returns to work. Feel free to request of the employee or employer a list of the essential job functions.

1. Once the employee returns to work, will the employee be unable to perform work of any kind?

   _____Yes _____No

2. If the employee will be unable to perform all job functions, will the employee be unable to perform any one or more of the essential functions of the job? If yes, please list the essential job functions the employee is unable to perform.

   _____

   _____

   _____

   _____

   _____

SECTION 3: For Completion By **PHYSICIAN**

CONTINOUS LEAVE <u>ONLY</u>

<u>Please fill out this section if the patient needs to be out continuously due to the patient's own serious health condition.</u>

Will patient need to be absent from work and/or unable to participate in regular daily activities **continuously** for illness, incapacity, and/or treatment? _____Yes _____No

Comments:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

SECTION 4: For Completion By **PHYSICIAN**

INTERMITTENT LEAVE <u>ONLY</u>

<u>Please fill out this section if the employee needs to be out of work intermittently (interrupted, non-continuous) due to the patient's own serious health condition.</u>

1. Will the patient need to be out of work and/or unable to participate in regular daily activities on an **intermittent basis** for illness or incapacity? _____Yes _____No

   If yes, please provide the following for any and all that apply:

   a. Will absences be planned and scheduled (e.g., predicable recovery periods after chemotherapy, etc.)?

      _____Yes _____No

   b. Will absences be unplanned and unscheduled (e.g., episodic incapacity)?

      _____Yes _____No

2. Will the patient need to be out of work on an **intermittent basis** to attend appointments (for treatments, therapy, etc.) due to the serious health condition indicated in **<u>Section 2, Part A: Medical Facts</u>**? _____Yes _____No

   If yes, please provide the following:

   a. General description of type of appointments:

      _____

      _____

      _____

      _____

      _____

   b. Number of appointments needed: _____

   c. Scheduled dates of appointments:

      _____

      _____

      _____

      _____

      _____

   d. Recovery duration (if applicable): _____

SECTION 4: For Completion By **PHYSICIAN**

INTERMITTENT LEAVE <u>ONLY</u>

(continued)

3. Will the patient need to work a reduced schedule due to periods of incapacity? (Note: **Incapacity**, for purposes of FMLA, is defined as inability to work, attend school, or perform other activities of daily living (ADLs) due to a serious health condition, and/or treatment for and/or recovery from the serious health condition.) _____Yes _____No

   If yes, please provide the following details regarding the requested reduced work schedule:

   a. Requested start date of reduced work schedule: _____

   b. Requested end date of reduced work schedule: _____

   c. Number of days per week available for work: _____

   d. Number of hours per day available for work: _____

4. Will the serious health condition cause episodic incapacity that will prevent the employee from working?

   _____Yes _____No

   If yes, based on the patient's medical history, please estimate the frequency of episodic incapacity:

   a. Times per week: _____

   b. Weeks per month: _____

CERTIFICATION

Please print clearly in all sections except Signature

First and last name of medical professional | Type of practice

Signature of medical professional | Date

Street Address | City, State | Zip

Telephone number | Email address