Clear Form

MIAMI-DADE COUNTY PUBLIC SCHOOLS

INTERMITTENT LEAVE REQUEST MEDICAL CERTIFICATION

UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

SUBMIT TO WORKSITE ADMINISTRATOR

For Completion by the EMPLOYEE:

EMPLOYEE NAME (PRINT)	EMPLOYEE NUMBER	TODAY'S DATE

PLEASE CHECK ONE:

☐ **FOR ILLNESS OF EMPLOYEE** ☐ **FOR ILLNESS OF FAMILY MEMBER** _____

Family Member Name

If request is for illness of family member indicate the relationship _____and age _____if it is for a son or daughter. Describe care you will provide to your family member and estimate length of leave needed to provide care. _____

_____

The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support your request for FMLA. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. Time taken as part of the intermittent leave request constitutes designation of your FMLA entitlement.

For Completion by the Healthcare Provider: _____

Patient Name

- **Diagnosis** _____ **ICD:** _____
- Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? ☐ Yes ☐ No
- Recommended intermittent leave of absence dates are from _____ to _____
  Date (be specific) Date (be specific)
- Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☐ Yes ☐ No
- Is it medically necessary for the employee to be absent from work during the flare-ups?
  ☐ Yes ☐ No
- 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 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

  Frequency: _____ times per _____ week(s) _____ month(s)

  PROVIDER'S COMMENTS:_____

  _____

Physician's Name Printed	Physician's Signature	Date

Specialty	Phone Number