# Hays Consolidated Independent School District
# Medical Certification for CLB

A complete medical certification is required to determine whether your health condition, or the health condition of your Spouse, Child (under the age of 18) or Parent, qualifies for leave under the Temporary Disability Leave, Short Term Leave, Extended Leave, Catastrophic Leave Bank (CLB) or Sick Leave Pool (SLP) regulations.

**Instructions to Employee:** Complete Sections I and III. If you are requesting leave care for your Spouse, Child (under the age of 18) or Parent who has a serious health condition, complete Section II as well. Your health care provider or your family member's health care provider must complete Sections IV through VII. **It is your responsibility to ensure the health care provider completes and returns these forms to the appropriate fax number provided below within 15 calendar days from the date of your request.**

**Instructions to Health Care Provider:** Your patient, or a family member of your patient, has requested a Leave of Absence. In order for us to verify whether this qualifies for protected leave, you must complete Sections IV through VII (page 2) of this form.
**Please fax the completed Medical Certification to 512.268.7384 Attn: Stephanie Ricke**

**Important Notice Regarding GINA:** The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual, except as specifically allowed by this law. To comply with this law, we are asking that you **not provide any genetic information when responding to this request for medical information.** "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

## SECTIONS I through III: For completion by the Employee

### Section I - Patient Information (Print)

Employee's Name: _____

Employee's Phone Number: _____

Employee's Mailing Address: _____

### Section II - Care for Family Member (Print)

Patient's Name: _____

Relationship to Employee: _____ If child, provide date of birth: ____/____/____

### Section III - Employee Signature

I authorize the Hays Consolidated Independent School District Office of Human Resources or it's designated health care provider/third party administrator to contact my health care provider or my family member's health care provider for purposes of obtaining clarifying information and authenticity of the medical information, if necessary.

_____ ____/____/____

Employee Signature Date

Stephanie Ricke, HR Leave Specialist | Phone: 512-268-8975 | Fax: 512-268-7384
Hays CISD | 21003 IH 35 | Kyle, TX 78640

Sections IV through VII: For completion by the Health Care Provider

**Section IV - Patient Information (Please print)**

1. Employee's Name: _____

2. Patient's Name: _____

3. Patient's relationship to the employee: ☐ Self ☐ Spouse ☐ Child ☐ Parent

**Section V - Designation of Serious Health Condition (Please print)**

4. Does the patient's condition for which leave is being requested qualify as a Serious Health Condition?
☐ Yes ☐ No

**Section VI-Duration of Incapacity and Treaments**

5. Indicate relevant medical facts
(i.e. symptoms, diagnosis, regimen of treatment)

6. State the approximate date the condition commenced:
_____/_____/_____

7. Estimate the probable duration of the condition:
_____/_____/_____ to _____/_____/_____

8. Was patient referred to another health care provider for evaluation or treatment (i.e. physical therapist?)
☐ Yes ☐ No
If yes, please state the nature of such treatments and expected frequency and durations of treatment:

9. Will the patient be incapacitated for a single continuous period of time due to the medical condition?
☐ Yes ☐ No
If yes, please estimate beginning and ending dates.
_____/_____/_____ to _____/_____/_____

10. Will the employee need to attend follow-up treatment appointments or be on a reduced schedule because of the medical condition? ☐ Yes ☐ No
If yes, are the treatments or the reduced number of hours of work medically necessary? ☐ Yes ☐ No
If yes, please estimate treatment schedule/appointments or reduced work schedule:
Frequency:_____ times per:
week(s)_____month(s)_____other_____
Duration:_____hours or _____day(s) per episode

11. If condition causes episodic flare-ups during these periods, will it be necessary for the patient to be absent from work? ☐ Yes ☐ No
If yes, please provide the:
Frequency:_____ times per:
week(s)_____month(s)_____other_____
Duration:_____hours or _____day(s) per episode

12. Additional information:

**Section VII - Physician Information**

Name of Health Care Provider (Print):_____ Provider's Signature:_____

Type of Practice:_____ Address:_____

Telephone Number:_____ Fax Number:_____ Date:_____/_____/_____