CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS HEALTH CONDITION

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

The Family and Medical Leave Act (FMLA) allows the IHB, as your employer, to require that an employee seeking leave due to their own serious health condition have their healthcare provider complete this form to provide the information necessary for a complete and sufficient medical certification as set out in 29 CFR § 825.305. You will be given at least 15 calendar days to return this form. Failure to provide a complete and sufficient medical certification may result in our denial of your FMLA request (29 CFR § 825.313). No certification form is required for leave to bond with a healthy newborn child or a child placed for adoption or foster care. Information about the FMLA can be found at www.dol.gov. If you have any questions regarding this form or if you need a copy of your functional job description to give to your physician, please contact the HR/LR Manager at 219-989-4850.

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

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE:
Please complete Section II in its entirety before giving this form to your medical provider. The FMLA permits us to require that you submit a timely, complete and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. You are responsible for ensuring that a complete medical certification is provided to your employer within the time frame requested. (29 CFR § 825.305-825.306)

Your Name: _____

Your IHB ID# _____ Your Department _____

Your Job Title _____ Regular work schedule _____

Your essential job functions _____

Is job safety sensitive? _____ Yes _____ No

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)

Description of needs/leave requested: _____
_____
_____

Beginning date of leave requested: _____

_____ _____
Employee Signature Date

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER:

Your patient has requested leave under the FMLA. The FMLA allows an employer to require that an employee submit a timely, complete and sufficient medical certification to support a request for FMLA due to the serious health condition of the employee. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves inpatient care or continuing treatment by a health care provider. Definitions of a serious health condition, incapacity, inpatient care and continuing treatment by a health care provider as described under the FMLA, can be found on page 6.

PROVIDER NAME: _____

PRACTICE/FACILITY NAME: _____

TYPE OF PRACTICE/MEDICAL SPECIALTY _____

ADDRESS: _____

PHONE: _____ FAX: _____

EMAIL ADDRESS: _____

PART A: MEDICAL FACTS/TYPE OF LEAVE

Please answer all questions fully and completely. Your answers should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage.

Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, genetic services, or the manifestation of disease or disorder in the employee's family members as defined in 29 CFR § 1635.3.

Please see page 6 for definitions of a serious health condition and incapacity under the FMLA.

Please be sure to sign and date the form on the last page.

1. Approximate date condition started or will start: _____ (mm/dd/yyyy).

2. Approximate duration condition lasted or will last: _____

3. Was medication, other than over-the-counter medication, prescribed to treat this condition?

   _____ Yes _____ No

   (If yes, and employee performs safety sensitive job duties,

   Form MD1000 - Safety Sensitive Employee Drug Report must be completed)

4. Check all that apply and provide any additional requested information. For all boxes checked, amount of leave needed must be provided in Part B.
Additional description of a serious health condition as defined under the FMLA found on page 6

□ **Inpatient Care:** The patient (□ has been/ □ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility due to this condition.
List dates of admission: _____

□ **Incapacity plus Treatment:** (e.g. outpatient surgery, strep throat)
Due to the condition, the patient (□ has been/ □ is expected to be) incapacitated for more than three consecutive, full calendar days.
List dates of incapacitation: From _____ (mm/dd/yyy) to_____ (mm/dd/yyy)

The patient (□ was/ □ will be) seen on the following date(s): _____
_____

The condition (□ has/ □ has not) also resulted in a course of continuing treatment under the supervision of a health care provider. (e.g. prescription medication (not over-the-counter) or therapy requiring special equipment)
Please describe continuing treatment: _____
_____

If medication (other than over-the-counter) was prescribed and employee's job is safety sensitive, form MD1000 must be completed.

□ **Pregnancy:** The condition is pregnancy. Expected due date: _____(mm/dd/yyyy).

□ **Chronic Conditions:** (e.g. asthma, migraines) Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.
List dates patient has been treated due to this condition in the past 2 years:
_____

□ **Permanent or Long Term Conditions:** (e.g. Alzheimer's, terminal stages of cancer)
Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

□ **Conditions requiring Multiple Treatments:** (e.g. Chemotherapy, restorative surgery) Due to the condition, it is medically necessary for the patient to receive multiple treatments.

□ **None of the Above:** None of the above apply to this patient's condition. No additional information is needed. Please go to page 5 and sign and date the form.

5. Describe any other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. (e.g. use of nebulizer, dialysis, continued treatment, etc.) _____

_____

_____

6. Due to the condition, the employee (□ was not/ □ is not/ □ will not be) able to perform one or more essential functions of his/her job. If so, identify the job functions the employee is unable to perform. (If you need a copy of the IHB's functional job description, please contact the HR/LR Manager at 219-989-4850)

_____

_____

_____

PART B: AMOUNT OF LEAVE NEEDED

For the medical condition(s) checked in Part A, complete all that apply. Several questions seek a response as to the frequency and duration of a condition, treatment, etc. Your answers should be your best estimate based on 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.

7. Due to the condition, the patient (□ had/ □ will have/ □ will not have) planned medical treatment(s) (scheduled medical visits) (e.g. psychotherapy, prenatal appointment, etc.) on the following date(s):

_____

_____

The patient (□ will/ □ will not) be able to work when not attending appointments for planned medical treatment.

8. Due to the condition, the patient (□ was/ □ will be/ □ will not be) referred to another health care provider(s) for evaluation or treatment.

a) State the nature of such evaluation or treatment: (e.g. cardiologist, physical therapy, etc.)

_____

b) Provide your best estimate for the beginning date _____(mm/dd/yyyy) and end date _____(mm/dd/yyyy) for the treatment.

c) Provide your best estimate for the duration of the treatment, including any period for recovery. (e.g. ____ hours per day, ___ days per week, etc.)_____

d) The patient (□ will/ □ will not) be able to work while waiting for or during evaluation or treatment with other health care provider.

9. Due to the condition, it (□ is/ □ is not) medically necessary for the patient to work a reduced schedule. (A reduced schedule would be a minimum number of hours per day or days per week. This is not the same as an intermittent leave)

   If so, provide your best estimate of the reduced schedule the employee is able to work:
   From _____(mm/dd/yyyy) to _____(mm/dd/yyyy), employee is able to work the following: _____
   (e.g. ___ hours per day, ___ hours per week)

10. Will the employee be incapacitated, including any time for treatment and recovery, for a single continuous period of time or on an intermittent basis over a period of time?

    _____ Single Continuous _____ Intermittent

    a) If the employee was/will be absent for a **single continuous period of time**, provide your best estimate of the beginning and ending dates of the period of incapacity:

    The employee (□ is/ □ was/ □ will be) incapacitated due to the condition and unable to work from _____(mm/dd/yyyy) to _____(mm/dd/yyyy).

    b) If the employee was/will be absent **intermittently over a period of time** due to episodes of incapacity (e.g. episodic flare-ups), provide your best estimate of the beginning and ending dates along with the frequency and duration of the periods of incapacity:

    The employee (□ is/ □ was/ □ will be) incapacitated due to the condition and unable to work intermittently from _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy) approximately _____ times per (□ week/ □ month/ □ year) lasting for approximately _____ (□ hours/ □ days) per episode.

    c) The employee (□ will/ □ will not) need to see a physician during the flare-ups.

ADDITONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

If you have any questions while filling out this form or need a functional job description for the employee's position sent to you, please contact the HR/LR Manager at 219-989-4850.

If the IHB has questions or needs clarification regarding the information submitted on this form, please provide the contact information of a person at your office who can provide clarification.

NAME: _____
EMAIL: _____
PHONE: _____

_____ _____

Signature of Health Care Provider **Date**

Definitions of a Serious Health Condition (See 29 CFR § 825.113-115)

Serious Health Condition

A serious health condition means an illness, injury, impairment, or physical or mental condition that involves inpatient care or continuing treatment by a health care provider.

Incapacity

For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition.

Inpatient Care

- An overnight stay in a hospital, hospice, or residential medical care facility.
- Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.

Continuing Treatment by a Health Care Provider (any one or more of the following)

Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either:

- Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity: or,

- At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.

Pregnancy: Any period of incapacity due to a pregnancy or for prenatal care.

Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma or migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.

Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.

Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury or a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.