CERTIFICATION OF HEALTH CARE PROVIDER FOR
FAMILY MEMBER'S SERIOUS HEALTH CONDITION (FMLA)

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 an employee seeking FMLA leave due to a need for leave to care for a covered family member with a serious health condition to have their family member's health care 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). Additional information about the FMLA can be found at www.dol.gov. If you have any questions regarding this form please contact the HR/LR Manager at 219-989-4850.

Employer name and contact: Indiana Harbor Belt Railroad, HR/LR Manager (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 family member's medical provider. You are responsible for ensuring that a complete medical certification is provided to your employer within the time frame requested. (29 CFR § 825.305-306)

Your Name: _____

Your IHB ID# _____ Dept. _____ Job Title _____

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)

Name of family member for whom you will provide care _____

Relationship of family member to you : □ Spouse □ Parent □ Child under age 18
□ Child age 18 or older who is incapable of self-care due to a mental or physical disability

(A spouse is a husband or wife as defined or recognized in the state where the individual was married, including common law or same-sex marriages.) (The terms "child" and "parent" include 'in loco parentis' relationships.)

Describe the type of care you will provide to your family member: (check all that apply and describe below)
□ Assistance with basic medical, hygienic, nutritional or safey needs □ Transportation
□ Physical Care □ Psychological Comfort □ Other
Describe here:_____
_____

Are you needed to provide care on an intermittent basis or for a continuous block of time?
□ Intermittently □ Continuous block of time

Beginning date of leave requested: _____

Estimate of amount of leave needed to provide care _____

_____ _____
Employee Signature Date

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER:
The family member of your patient listed on page one has requested leave under the FMLA to care for your patient. The FMLA allows an employer to require that an employee submit a timely, complete and sufficient medical certification to support a request to care for a family member with a serious health condition.
Please answer all questions fully and completely. Be as specific as you 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 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 be sure to sign and date the form on the last page.

Please see page 5 for definitions of a serious health condition and incapacity under the FMLA.

PROVIDER NAME: _____
PRACTICE/FACILITY NAME: _____
TYPE OF PRACTICE/MEDICAL SPECIALTY _____
ADDRESS: _____
PHONE: _____ FAX: _____

PART A: MEDICAL FACTS

1. Patient's name: _____

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

3. Estimate of how long the condition lasted or will last: _____

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 5.

□ **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/yyyy) to _____ (mm/dd/yyyy)

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: _____
_____

- □ **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: _____
  _____

- □ **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. If you checked this box, no additional information is needed. Please go to page 4 and sign and date the form.

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

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 the condition, treatment, etc. Your answers should be your best estimate based upon 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.

6. 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):
   _____
   _____

7. 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.)_____

8. Will the patient be incapacitated and need care from the employee (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 patient was/will be incapacitated due to the condition and need care from the employee for a **single continuous period of time**, provide your best estimate of the time needed below.
The patient (□ is/ □ was/ □ will be) incapacitated due to the condition and need continuous care from the employee from _____(mm/dd/yyyy) to _____(mm/dd/yyyy).

b) If the patient was/will be incapacitated and need care from the employee **intermittently over a period of time**, due to episodes or flare-ups of the conditon (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 patient (□ is/ □ was/ □ will be) incapacitated due to the condition and need care intermittently from the employee from _____(mm/dd/yyyy) to _____(mm/dd/yyyy)
_____ times per (□ week/ □ month/ □ year) lasting for approximately _____ (□ hours/ □ days) per episode.

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

9. For FMLA to apply, care of the patient must be medically necessary. Please explain the care needed for the patient from the employee and why such care is medically necessary:

_____

_____

_____

ADDITONAL INFORMATION: PLEASE LIST ANY ADDITIONAL INFORMATION NEEDED TO CLARIFY YOUR ANSWERS OR THE LEAVE NEEDED:

_____

_____

_____

_____

If you have any questions while filling out this form, 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.