CERTIFICATION OF HEALTH CARE PROVIDER
(Family and Medical Leave Act of 1993)

SECTION 1: EMPLOYER INFORMATION

Employer Name and Contact: Union Pacific Railroad
Health & Medical Services Department
1-877-275-8747 option 4
FAX: 402-233-3305

TO BE COMPLETED BY THE EMPLOYEE:

INSTRUCTIONS to the EMPLOYEE: Please complete this section before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Employee's Name: _____ Job Title: _____

Employee's Phone Number: _____ Service Unit or Department:_____

Employee ID:_____ Supervisor:_____

Reason for leave: ☐ Birth of an employee's Child (Estimated due date _____)
☐ Own Serious Health Condition
Care of: ☐ Parent ☐ Spouse ☐ Child (age _____)

Type of Leave: ☐ Block ☐ Intermittent ☐ Reduced Work Schedule

If leave request is for the employee's own serious health condition:

- Is the serious health condition for which you are requesting leave related to an on duty injury? ☐ Yes ☐ No
- Check if job description is attached: ☐
- List the essential functions of your job: _____

If leave request is for the care of a family member:

- Describe care you will provide to your family member and estimate leave needed to provide care:

_____

Clarification of the Form

The Department of Labor Regulations allows employers to contact your health care provider to clarify the medical certification provided by the health care provider.

In the event my certification is incomplete or insufficient to determine FMLA coverage:

- ☐ I prefer that a representative of Union Pacific Health & Medical Services contact my Health Care Provider directly, if necessary for purposes of obtaining complete information or clarification of the medical certification.
- ☐ I prefer that the incomplete or insufficient certification be returned to me for the opportunity to cure any deficiencies.

While an employee may choose to comply with the certification requirement by providing the employer with an authorization, release, or waiver allowing the employer to communicate directly with the health care provider of the employee or his or her covered family member, the employee may not be required to provide such an authorization, release, or waiver. In all instances in which certification is requested, it is the employee's responsibility to provide the employer with complete and sufficient certification and failure to do so may result in the denial of FMLA leave. See Sec. 825.305(d).

Employee's Signature _____ Date _____

Family Member's Signature _____ Date _____

Return to: Union Pacific Railroad - Health and Medical Department - 1400 Douglas St. Stop 0350 - Omaha, NE 68179
OR Fax to: 402-233-3305

Employee Name: _____ Employee ID #: _____

TO BE COMPLETED BY THE HEALTH CARE PROVIDER:

INSTRUCTIONS to the HEALTH CARE PROVIDER: Answer, fully and completely, all applicable parts below. *Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer 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," "as needed," or "indeterminate" may not be sufficient to determine FMLA coverage*. Limit your responses to the condition for which the patient needs leave. Please be sure to sign the form on the last page.

Patient's Name: _____

Relationship to Employee: _____ If patient is employee's child - age: _____

1. **Describe** the medical facts which support the certification of the **patient's** serious health condition (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

   _____

   _____

   _____

2. Was the patient admitted for an overnight stay in the hospital, hospice, or residential medical care facility? ☐ Yes ☐ No
   Date(s) of admission: _____ Duration of stay: _____

3. Is the medical condition pregnancy? ☐ Yes ☐ No If so, expected delivery date: _____

4. **Incapacity, for the purposes of FMLA is defined as the inability to perform one or more essential job functions, attend school or perform other regular daily activities due to the serious health condition, treatment therefore or recovery there from*.

   What activities of daily living or essential job functions is the patient unable to perform when he or she is incapacitated by their condition?

   _____

   ☐ The patient's condition does not cause periods of incapacity.

   If the patient is incapacitated by their condition, is this a condition that would cause the patient to experience either a:

   ☐ A onetime continuous **block** of incapacity

   - If so when did or when do you expect this period of incapacity to begin? _____
   - How long do you estimate the patient's period of incapacity will last? _____

   ☐ **Episodic** flare-ups of incapacity

   - When did this condition begin? _____

     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.

     Frequency (unknown or indeterminate is insufficient to determine FMLA coverage):

     _____ times per _____ week(s) _____ month(s) _____ year

     Duration (unknown or indeterminate is insufficient to determine FMLA coverage):

     _____ hours or _____ day(s) per episode

   - How far into the foreseeable future do you estimate the patient will continue to experience incapacity at the frequency and duration indicated above?_____

Employee Name: _____ Employee ID #: _____

5. Did the patient have an office visit? ☐ Yes ☐ No Date(s) of visit(s): _____

   Scheduled or estimated interval of follow up visit(s) (as needed or indeterminate not sufficient to determine FMLA coverage):

   _____

   Was medication, other than over the counter medication, prescribed? ☐ Yes ☐ No

   Will the patient need to have treatment visits at least twice per year due to the medical condition? ☐ Yes ☐ No

6. Will the patient require other treatments in addition to the follow-up visits listed above? ☐ Yes ☐ No

   State the nature of such treatments: _____

   Date the treatment began: _____ The probable duration of such treatment: _____

   The estimated number of treatments: _____ The Approximate interval of treatments: _____

   Recovery period due to treatment required: _____

   Does the employee require a part time or reduced work schedule? ☐ Yes ☐ No

   If yes estimate the part-time or reduced work schedule the employee needs _____ hour(s) per day; _____ days per week from _____ through _____

7. Is it medically necessary for the employee to be absent from work to attend or provide assistance during visits for treatment? ☐ Yes ☐ No

AMOUNT OF CARE NEEDED (FOR EMPLOYEES SEEKING LEAVE TO CARE FOR A FAMILY MEMBER): When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

8. Describe the physical or psychological care the patient **requires** from their family member.

   _____

   _____

   _____

9. What is the probable amount of time away from work the employee will need to provide the assistance to their family member as described above? (As needed or indeterminate not sufficient to determine FMLA coverage.)

   _____

HEALTH CARE PROVIDER INFORMATION

Name (please print):_____ Type of Practice / Specialty: _____

Clinic / Hospital: _____ Area Code and Phone Number: _____

Address _____ Fax Number: _____

City:_____ State: _____ Zip Code: _____

Signature: _____ Date: _____

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500.Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

Return to: Union Pacific Railroad - Health and Medical Department - 1400 Douglas St. Stop 0350 - Omaha, NE 68179
OR Fax to: 402-233-3305