Adult Child Disability Medical Inquiry for FMLA

This form required ONLY if employee is requesting FMLA to care for child 18 years of age or older.

To approve your request for FMLA leave to care for an adult child, Henry County Schools is requesting medical information and documentation to determine if the adult child has a disability as defined by the Americans with Disabilities Act (ADA) and amendments. Please have the adult child's medical care provider complete this form. Return the completed form to the Henry County Schools FMLA Office with the medical certification of your adult child's serious health condition.

This section to be completed by Employee:

Employee Name (print):_____Employee Number: _____

Name of Adult Child (Patient): _____Date of Birth:_____

Employee Signature: _____ Date: _____

To be completed by Adult Child's Health Care Provider:

In order for a parent to take FMLA leave to care for a child who is age 18 or over, the son or daughter must:

- *Have a disability as defined by the ADA;*
- *Be incapable of self-care due to that disability;*
- *Have a serious health condition; and,*
- *Be in need of care due to the serious health condition.*

It is only when all four requirements are met that an eligible employee is entitled to FMLA–protected leave to care for his or her adult son or daughter.

1. Does the adult child have a disability as defined by the ADA? Defined as a physical or mental impairment that substantially limits one or more of the major life activities of an individual? Yes ____ No ____

2. Can you confirm that the daughter's or son's disability causes them to be "incapable of self-care" in at least three "daily living activities" (please identify) listed below? Yes _____ No _____

Please check applicable activities:

___ Grooming and hygiene.
___ Bathing and dressing.
___ Feeding and eating.
___ Cooking and preparing meals.
___ Cleaning of dishes and of clothing.
___ Shopping for normal basic living.
___ Taking public transportation.
___ Paying bills, using a bank and post office.
___ Helping to maintain a residence.
___ Other (please specify) _____

3. What is the probable duration of the disability? _____

4. What is the probable duration of the serious health condition requiring FMLA? _____

5. Describe any other relevant facts, if any, related to the son or daughter's care: _____
_____
_____

Health Care Provider's Signature: _____ Date: _____

Health Care Provider's Printed Name: _____

Treating Health Care Provider's Address and Telephone Number: Telephone Number: _____

Return complete FMLA application to:	Henry County Schools Human Resource Services-FMLA Office 33 N. Zack Hinton Parkway McDonough, GA. 30253	OR	FAX number: 770-954-9202
Email to: FMLA@henry.k12.ga.us			**Phone number: 770-957-5107**