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Certification of Health Care Provider for Family Member's Serious Health Condition (Family and Medical Leave Act)

SECTION I: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section I before giving this form to your family member or his/her 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 to care for a covered family member with a serious health condition. 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. 29 C.F.R. § 825.313. You must return this form to Human Resources within 15 calendar days. 29 C.F.R. § 825.305.

Your name:_____
First Middle Last

Employee Number_____ Department_____

Name of family member for whom you will provide care:_____
Relationship of family member to you: _____
If family member is your son or daughter, provide date of birth: _____

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

_____

_____

_____ DATE_____
EMPLOYEE SIGNATURE

SECTION II: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. 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 "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address:_____

Type of practice / Medical specialty: _____

Telephone: _____ Fax_____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition:_____

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? _____Yes _____No

   If so, dates of admission: _____

   Date(s) you treated the patient for condition:_____

   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 condition?

   _____Yes _____No

2. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g. physical therapist?) _____Yes _____No If so, please indicate the nature of the treatments and the expected duration:

_____

_____

3. Is the medical condition pregnancy? _____Yes ____No Expected date of delivery_____

4. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

PART B: AMOUNT OF CARE NEEDED: 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:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery?_____Yes _____No

Estimate the beginning and end dates for the period of incapacity:_____

During this time, will the patient need care? _____Yes _____ No

Explain the care needed by the patient and why such care is medically necessary:

_____

_____

_____

_____

_____

5. Will the patient require follow-up treatments, including any time for recovery? ___ No ___Yes

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

_____

Explain the care needed by the patient, and why such care is medically necessary:

_____

_____

6. Will the patient require follow up treatments, including any time for recovery?
_____Yes _____No

Explain the follow up care needed, and why such care is medically necessary:_____

_____

_____

7. Estimate the hours the patient needs care on an intermittent basis, if any:

_____hour(s) per day;_____days per week from _____through_____

Explain the care needed by the patient, and why such care is medically necessary:

_____

_____

_____

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? _____No _____Yes

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 that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: ____times per _____week(s) _____month(s)

Duration: ___ hours or _____day(s) per episode

Does the patient need care during these flare-ups? _____No _____Yes

Explain the care needed by the patient, and why such care is medically necessary: _____

_____

_____

ADDITIONAL INFORMATION : IDENTIFY QUESTION NUMBER WITH ANSWER

_____

_____

_____

_____

_____

_____

SIGNATURE OF HEALTH CARE PROVIDER_____

DATE_____