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**CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE'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 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 due to your own 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. 20 C.F.R. § 825.313. You have 15 calendar days to return this form to Human Resources. 29 C.F.R. § 825.305(b).

Employee Name \_\_\_\_\_ Employee Number \_\_\_\_\_

Employee's job title: \_\_\_\_\_ Regular work schedule: \_\_\_\_\_

Employee's essential job functions: \_\_\_\_\_  
\_\_\_\_\_

Job Description is Attached  Yes  No

**SECTION II: For Completion by the HEALTH CARE PROVIDER**

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. 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 employee is seeking leave. Please be sure to sign the form on the last page.

Provider's name and business address \_\_\_\_\_  
\_\_\_\_\_

Medical Specialty \_\_\_\_\_ Telephone \_\_\_\_\_

**PART A: MEDICAL FACTS**

1. Approximate date condition commenced: \_\_\_\_\_

**Mark below as applicable:**

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? \_\_\_\_\_No \_\_\_\_\_Yes. If so, dates of admission:

\_\_\_\_\_

Date(s) you treated the patient for condition:

\_\_\_\_\_

Will the patient need to have treatment visits at least twice per year due to the condition?

\_\_\_\_\_No \_\_\_\_\_Yes

Was medication, other than over-the-counter medication, prescribed? \_\_\_\_\_No \_\_\_\_\_Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? \_\_\_\_\_No \_\_\_\_\_Yes. If so, state the nature of such treatments and expected duration of treatment:

\_\_\_\_\_

2. Is the medical condition pregnancy? \_\_\_\_\_No \_\_\_\_\_Yes. If so, expected delivery date:

\_\_\_\_\_

3. Use the information provided concerning employee's essential job functions in Section I to answer this question. If there is no information provided concerning the employee's essential functions or a job description, answer these questions based upon information provided by the employee as to his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition?

\_\_\_\_\_No \_\_\_\_\_Yes

If so, identify the job functions the employee is unable to perform:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

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**PART B: AMOUNT OF LEAVE NEEDED**

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? \_\_\_\_\_No \_\_\_\_\_Yes

If so, estimate the beginning and ending dates for the period of incapacity:

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6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? \_\_\_\_\_No \_\_\_\_\_Yes.

If so, are the treatments or the reduced number of hours of work medically necessary? \_\_\_\_\_ 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:

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Estimate the part-time or reduced work schedule the employee needs, if any:

hour(s) per day; \_\_\_\_\_ days per week from \_\_\_\_\_ through

Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? No Yes.

Is it medically necessary for the employee to be absent from work during the flare-ups? No Yes. If so, explain:

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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

**ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR  
ADDITIONAL ANSWER.**

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**Signature of Health Care Provider** \_\_\_\_\_

**Date** \_\_\_\_\_