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

Employer name and contact:____

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 Family and Medical Leave Act (FMLA) permits an employer to require that you submit timely, complete, and sufficient medical certification to support a request for FML to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FML 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 FML 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).

Your name:____
First Middle Last

Name of family member for whom you will provide care:

____
First Middle Last

Relationship of family member to you:

____

If family member is your son or daughter, date of birth: ____________________________________

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

____
____
____

Employee Signature:

____Date__________________

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 FML 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. Description of medical condition:____

Probable duration of condition:____

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:____

Was medication, other than over-the-counter medication, prescribed? No:___ Yes:___

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

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____
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2. Is the medical condition pregnancy? No___ Yes___ If so, expected delivery date:_______________________________________

3. Describe other relevant medical facts, if any, related to the condition for which the patient seeks leave (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 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?
No___ Yes___

Estimate the beginning and ending dates for the period of incapacity: ____

During this time, will the patient need care? No___ Yes___

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:

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

____
____
____
____

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? No___ Yes___

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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______________________

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

____
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____
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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) ___________ months(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:

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PART B: Additional Information: Identify question number with your additional answer.

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Signature of health care Provider_______________________________________ Date ____________________________________

Direct questions and return form and any required documentation to the Office of Human Resources.

Keep a copy for your personal records.