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

Employer name and contact:_____

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

Employee's essential job functions:_____

☐Check if job description is attached.

Section I: For Completion by the EMPLOYEE:

Instructions to the employee: Please complete Section I before giving this form to your 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 due to your own 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

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 FML 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:_____

Type of practice/medical specialty:_____

Telephone:_____ Fax:_____

PART A: Medical Facts:

1. Description of medical condition:_____

Probable duration of condition:_____

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 by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of 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 (medical facts may include symptoms, diagnosis, or any regimen of continuing treatment, such as the use of specialized equipment):

_____

_____

_____

_____

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:_____

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:

_____

_____

_____

_____

Estimate the part-time or reduced work schedule the employee needs, if any:
_____ hour(s) per day; _____ days per week from_____ through_____

7. 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:

_____

_____

_____

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_____

Direct questions and return form and any required documentation to the Office of Human Resources.
Keep a copy of this form for your personal records.