FAMILY AND MEDICAL LEAVE
CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS HEALTH CONDITION

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. If requested by your employer, 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. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. §825.305(b). **It is the employee's responsibility to ensure that sufficient medical certification is provided to the department.**

Your Name: _____
First, Middle, Last

SECTION II: FOR COMPLETION BY THE EMPLOYER

Employer Name: _____

Contact Information: _____

Employee's Job Title: _____

Employee's Regular Work Schedule: _____

Employee's Essential Job Functions: _____

_____

Check if job description is attached: ☐

SECTION III: FOR COMPLETION BY THE HEALTH CARE PROVIDER ONLY

Dear Health Care Provider:

The above-named employee has requested leave under the FMLA. This medical certification form will provide us with information to determine if the employee is eligible for FMLA leave. Section III must be completed fully and returned to the department by the employee or your office. 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 and review of the employee's job description.

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.*

For the purposes of this form, "incapacity" is defined as the inability to work, attend school, or perform other regular activities due to the serious health condition itself, treatment of the serious health condition, or recovery from the condition. "Treatment" includes examinations to determine if a serious health condition exists and evaluations for the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations. A regimen of continuing treatment includes, for example, a course of prescription medication [e.g., an antibiotic] or therapy requiring special equipment to resolve or alleviate the health condition. A regimen or treatment does not include taking over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, or other similar activities that can be initiated without a visit to a health care provider.

Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). Please be sure to sign the form on the last page.

Provider's Name [Printed]: _____

Provider's Business Address: _____

Type of Practice/Medical Specialty: _____

Telephone: (____)_____ Fax: (____)_____

SECTION III CONTINUED: FOR COMPLETION BY THE HEALTH CARE PROVIDER ONLY

Patient's Name: _____

SERIOUS HEALTH CONDITION

1. The definitions below describe what is meant by a "serious health condition" under the FMLA. Does the patient's condition(s) qualify under any of the categories described? If so, please check the appropriate category.

☐ **CATEGORY 1: In-Patient Care**

Any period of incapacity or treatment connected with inpatient care [i.e., an overnight stay] in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

☐ **CATEGORY 2: Absence Plus Treatment**

A period of incapacity of more than three (3) consecutive full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, which also involves:

1) Treatment two (2) or more times, within 30 days of the first day of incapacity, by a health care provider, by a nurse under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist), under orders of, or on referral by, a health care provider; or
2) Treatment by a health care provider on at least one (1) occasion, which results in a regimen of continuing treatment under the supervision of a health care provider (e.g. prescribed medication).

☐ **CATEGORY 3: Pregnancy or Prenatal Care**

Any period of incapacity due to pregnancy, or for prenatal care. Expected delivery date: _____

☐ **CATEGORY 4: Chronic Conditions**

Any period of incapacity or treatment for such incapacity due to a chronic serious health condition. A chronic serious health condition is one which:

1) Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;
2) Continues over an extended period of time, occurring episodes of a single underlying condition; and
3) May cause episodic rather than a continuing period of incapacity, e.g. asthma, diabetes, epilepsy, etc.

☐ **CATEGORY 5: Permanent or Long-Term Conditions Requiring Supervision**

Ay period of incapacity, which is permanent or long-term, due to a condition for which treatment may not be effective. The employee must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, severe stroke, or the terminal stages of a disease.

☐ **CATEGORY 6: Conditions Requiring Multiple Treatments**

Any period of absence to receive multiple treatments, including any period of recovery therefrom, by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, for:

1) Restorative surgery after an accident or other injury; or
2) A condition that would likely result in a period of incapacity of more than three (3) consecutive, full calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), or kidney disease (dialysis).

☐ **NO CATEGORY APPLIES**

Describe other relevant medical facts 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):

_____

_____

_____

_____

_____

SECTION III CONTINUED: FOR COMPLETION BY THE HEALTH CARE PROVIDER ONLY

Patient's Name: _____

PART A: SUPPORTING MEDICAL FACTS

1. Approximate date condition commenced: _____

   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. Use the information provided by the employer in Section II 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 <u>unable</u> to perform.

   _____

   _____

   _____

   _____

PART B: AMOUNT OF LEAVE NEEDED

3. 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: _____

SECTION III CONTINUED: FOR COMPLETION BY THE HEALTH CARE PROVIDER ONLY

Patient's Name: _____

IF THE EMPLOYEE IS ASKING FOR INTERMITTENT LEAVE OR A REDUCED WORK SCHEDULE, ANSWER THE FOLLOWING:

4. Is it medically necessary for the employee to be off work on an intermittent basis due to the employee's serious health condition? [If no, proceed to additional information at bottom of page] ☐ No ☐ Yes

   a) 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 yes, 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 or absence that the patient may have and for what period of time [e.g., "1 episode every 3 months lasting 1-2 days for the next six months"]:

   Frequency: _____ times per [circle] week/month and lasting _____ hours/days [circle] per episode

   Flare-ups may occur from [date]: _____ through: _____.

   Comments: _____

   _____

   b) Is it medically necessary for the employee to attend follow-up treatments or work part-time? ☐ No ☐ Yes

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

   _____

   _____

   c) Is it medically necessary for the employee to work a reduced work schedule due to the employee's serious health condition? ☐ No ☐ Yes

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

   _____ hour(s) per day; _____ days per week from _____ through _____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

Signature of Health Care Provider	**Date**
Printed Name of Health Care Provider	**Telephone Number**