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

SECTION I: For Completion by the EMPLOYEE

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. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. Your employer must give you at least 15 calendar days to return this form.

Employee Name _____ Employee ID _____

Name of patient for whom you will provide care: _____

Relationship of patient to you: _____

If patient is your son or daughter, date of birth: _____

Describe the 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

The employee listed above 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 Name _____ Specialty _____

Address _____ Phone _____

City, State, ZIP _____ Fax _____

PART A: MEDICAL FACTS

Retention Schedule: Upon completion, this form shall be retained permanently in the official and local medical file of the employee.

Approximate date condition commenced: _____

Probable duration of condition: _____

Date(s) you treated the patient for 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: _____

Is the medical condition pregnancy?
☐ No ☐ Yes If so, expected delivery date: _____

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:
_____

PART B: AMOUNT OF CARE NEEDED

Will the patient 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: _____
During this time, will the patient need care: ☐ No ☐ Yes
If so, explain the care needed and why such care is medically necessary: _____
_____
_____

Will the patient need to attend follow up treatment appointments due his/her medical condition?
☐ No ☐ Yes If so, estimate the treatment schedule, including any scheduled follow-up appointments.
_____
Explain the care needed and why such care is medically necessary: _____
_____
_____

Will the patient require care on an intermittent basis, including any time for recovery? ☐ No ☐ Yes
If so, estimate the hours of care the patient will need intermittently: _____
Explain the care needed and why such care is medically necessary: _____
_____
_____

Is the condition episodic in nature, periodically preventing the patient from perform his/her normal daily activities?

☐ No ☐ Yes If so, estimate the frequency and duration of these periods of incapacity._____

_____

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

_____

_____

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):

_____

_____

_____

_____

_____

_____ _____

Signature of Provider (No Stamps, Please) Date

Retention Schedule: Upon completion, this form shall be retained permanently in the official and local medical file of the employee.