



CERTIFICATION OF HEALTH CARE PROVIDER

Family Member's Serious Health Condition
Family and Medical Leave Act

SECTION I: FOR COMPLETION BY THE EMPLOYER

PLEASE RETURN COMPLETED FORM TO:

GEORGIA VOCATIONAL REHABILITATION AGENCY- OFFICE OF HUMAN RESOURCES
200 PIEDMONT AVENUE SE – 10TH FLOOR SUITE 1002 WEST TOWER
ATLANTA, GA 30334-1090

MAIN LINE: 404-232-1769

FAX:404-232-1968

SECTION II: FOR COMPLETION BY THE EMPLOYEE

INSTRUCTIONS TO THE EMPLOYEE: Please complete Section II before giving this form to your family member or his/her 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 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 FMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. **YOU HAVE 15 DAYS TO RETURN THIS FORM**

Employee Name: _____ **Date:** _____

Name of family member whom you will provide care: _____

Relationship of the family member to you: _____

If the 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: TO BE COMPLETED BY 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 FMLA coverage. Limit your responses to the conditions for which the patient is seeking leave. Do not provide information about genetic tests, or genetic services. 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: _____

Provider's Business Address: _____

Type of Practice/Medical Specialty: _____

Phone: _____ **Fax:** _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____ Probable duration of condition: _____

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? NO YES

If yes, date(s) of admission: _____

Date(s) you treated the patient for the condition: _____

Was medication, other than over-the-counter medication prescribed? NO YES

Will the patient need to have treatment visits at least twice a 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 duration of treatment:

2. Is the medical condition due to pregnancy? NO YES If so, expected delivery date: _____



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3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such 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: 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 end dates for the period of incapacity: ____/____/____ to ____/____/____

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 treatment, 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:

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

Estimate the hours the patient needs care on an intermittent basis, 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:

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) Month(s) **Duration:** _____ hrs 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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ADDITIONAL INFORMATION (IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER)

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| Signature of Health Care Provider: | | Date: | |
|------------------------------------|--|-------|--|

TO BE COMPLETED BY HUMAN RESOURCES

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| Official Action on Request: <input type="checkbox"/> APPROVED <input type="checkbox"/> DENIED <input type="checkbox"/> Employee Not Eligible for FMLA <input type="checkbox"/> Employee has exhausted FMLA entitlement | Notes: |
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| Human Resources Signature: | Date: |
|----------------------------|-------|