



## CERTIFICATION OF HEALTH CARE PROVIDER

Employee's Serious Health Condition  
Family and Medical Leave Act

### SECTION I: EMPLOYEE INFORMATION

**INSTRUCTIONS TO THE EMPLOYEE:** Please complete Section I before giving this form to your medical provider. You are required to submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. 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**

<b>Employee Name:</b>		<b>Date:</b>	
<b>Job Title:</b>	<b>Program:</b>	<b>Employee ID#</b>	
<b>Home Address:</b>			
<b>City:</b>		<b>State:</b>	<b>Zip:</b>
<b>Phone:</b>		<b>Cell:</b>	
<b>Employee Work Schedule: From:</b> ____ <input type="checkbox"/> AM/ <input type="checkbox"/> PM		<b>To:</b> ____ <input type="checkbox"/> AM/ <input type="checkbox"/> PM <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> T <input type="checkbox"/> F <input type="checkbox"/> S	
<b>Employee Essential Job Functions or see attached job description:</b>		<input type="checkbox"/> <b>Check if job description is attached</b>	

### SECTION II: TO BE COMPLETED BY 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 FMLA coverage. Limit your responses to the conditions for which the employee is seeking leave. Please be sure to sign the form on the last page.

<b>Provider's Name:</b>	
<b>Provider's Business Address:</b>	
<b>Type of Practice/Medical Specialty:</b>	
<b>Phone:</b>	<b>Fax:</b>

### PART A: MEDICAL FACTS

<b>Approximate date condition commenced:</b>	<b>Probable duration of condition:</b>
Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? <input type="checkbox"/> NO <input type="checkbox"/> YES	
If yes, date(s) of admission:	
Dates you treated the patient for the condition:	
Will the patient need to have treatment visits at least twice a year due to the condition? <input type="checkbox"/> NO <input type="checkbox"/> YES	
Was medication, other than over -the-counter medication prescribed? <input type="checkbox"/> NO <input type="checkbox"/> YES	
Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? <input type="checkbox"/> NO <input type="checkbox"/> YES	
If so, state the nature of such treatments and duration of treatment:	
2. Is the medical condition due to pregnancy? <input type="checkbox"/> NO <input type="checkbox"/> YES If so, expected delivery date:	
3. Use the information provided by the employer in Section I to answer this question. <i>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.</i>	
Is the employee unable to perform any of his/her job functions due to the condition: <input type="checkbox"/> NO <input type="checkbox"/> YES	
If so, identify the job functions the employee is unable to perform:	



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4. Describe the medical facts related to the condition for which the employee seeks leave (such 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 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 end dates for the period of incapacity: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

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:

Date: \_\_\_\_\_ Amt. of Time \_\_\_\_\_

# Hour(s) per day \_\_\_\_\_ # Days per week: \_\_\_\_\_

Date: \_\_\_\_\_ Amt. of Time \_\_\_\_\_

From Date: \_\_\_\_\_ Through Date: \_\_\_\_\_

Date: \_\_\_\_\_ Amt. of Time \_\_\_\_\_

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:** \_\_\_\_\_ hrs or \_\_\_\_\_ day(s) per episode

#### ADDITIONAL INFORMATION (IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER)

Signature of Health Care Provider: \_\_\_\_\_

Date: \_\_\_\_\_

#### TO BE COMPLETED BY HUMAN RESOURCES

Official Action on Request:  APPROVED  DENIED

Employee Not Eligible for FMLA

Employee has exhausted FMLA entitlement

Notes:

Human Resources Signature: \_\_\_\_\_

Date: \_\_\_\_\_