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

SECTION I: Completion by Employer

Employer Name: _____ Date: mm/dd/yyyy
(List date certification requested)

Contact: _____

The medical certification must be returned by mm/dd/yyyy
(*Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts*)

Employee's Job Title: _____ Regular Work Schedule: _____

Employee's Essential Job Functions:

Job Description ☐ is ☐ is not attached

SECTION II: Completion by Employee

Instructions to the Employee: Please complete Section II 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. 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.

Your Name: _____
First Middle Last

SECTION III: Completion 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 condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's Name: _____

Business Address: _____

Type of Practice/Medical Specialty: _____

Telephone: _____ Fax: _____

PART A: 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 treatment(s) 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 (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

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

8. Would employee be able to perform job duties, as outlined in the job description, remotely (i.e. from home)?
   ☐ No ☐ Yes

ADDITIONAL INFORMATION:
IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER

_____ _____
Signature of Health Care Provider Date