Certification of Health Care Provider
For Family Member's Serious Health Condition

(Family and Medical Leave Act)

SECTION I: Completion by Employer

Employer Name: _____ Date: _____ mm/dd/yyyy

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: _____

SECTION II: Completion by 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. Your employer must give you at least 15 calendar days to return this form to your employer.

Your Name: _____

First Middle Last

Name of family member for whom you will provide care: _____

First Middle Last

Relationship of family member to you: _____

If 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 III: Completion by Health Care Provider

Instructions to the Health Care Provider: The employee listed above has requested leave under 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 condition for which the patient needs leave. 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: _____

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. 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 the specialized equipment):

PART B: AMOUNT OF CARE 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 If so, estimate the beginning and ending dates for the period of incapacity:
   _____ _____
   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 treatments, 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: _____ hours 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:

ADDITIONAL INFORMATION:
IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER

Signature of Health Care Provider

Date