
Family and Medical Leave Act (FMLA)

Certification of Health Care Provider for Employee’s Serious Health Condition

SECTION I: For Completion by the EMPLOYEE

INSTRUCTIONS: Please complete Section I 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. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Employee Name: _____ Phone # _____

Home Address: _____

Job title: _____ School or Dept.: _____

Regular work schedule: _____

Essential job functions: _____

Check if job description is attached:

SECTION II: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS: 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. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e) or the manifestation of disease or disorder in the employee’s family members, 29 C.F.R. § 1635.3(b). Please be sure to sign the form on the last page.

Provider’s name: _____

Type of practice/Medical specialty: _____

Business address: _____

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 yes, 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 yes, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? No Yes If yes, expected delivery date: _____

3. Use the information provided in Section I to answer this question. If the employee fails to provide a list of the 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 yes, 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 yes, estimate period of incapacity: Beginning _____ Ending _____
Date Date

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 yes, are the treatments or the reduced number of hours of work medically necessary? No Yes

If 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 _____
Date Date

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 yes, 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: ___ episode(s) every: _____ week(s) month(s)

Duration: ___ hours or ___ day(s) per episode

ADDITIONAL INFORMATION: Identify question number(s) above with your additional answers.

Signature of Health Care Provider

Date