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

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the DEPARTMENTS/INSTITUTIONS: Please complete this section before providing this form to your employee. You may attach the job duties from the official Position Description. You are required to use this form and may not ask the employee to provide more information than is allowed under the Family Medical Leave Act (FMLA) regulations, 29 C.F.R. 825.306-825.308. You must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. 1630. 14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

Check if job description is attached: ☐

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete this section before giving this form to your health care 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 within 15 calendar days may result in a denial of your FMLA request.

Employee's Name: _____ Employee ID: _____

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER (see definition on last page): 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), 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 and return to the employee.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (____)_____ Fax: (____)_____

PART A: MEDICAL FACTS

1. Does the patient have a serious health condition? ☐ No ☐ Yes
   Please see definitions for a "serious health condition" under the FMLA on the last page of this document.
   Does the patient's condition meet one of these categories? If so, please check the applicable category.
   (1) ☐ (2) ☐ (3) ☐ (4) ☐ (5) ☐ (6) ☐ or None ☐

   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 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 treatments 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

ADDITIONAL INFORMATION: (IDENTIFY THE QUESTION THAT PERTAINS TO YOUR ADDITIONAL INFORMATION).

_____

_____

_____

_____

Signature of Health Care Provider: _____ **Date:** _____

Print name: _____

Definitions for Certification Form

A. **"Health Care Provider"**, for purposes of the FMLA, is a provider who may provide certification of a serious health condition and is one of the following:

1. A doctor of medicine or osteopathy authorized to practice medicine or surgery (as appropriate) by the State in which the doctor practices; or
2. A podiatrist, dentist, clinical psychologists optometrist, or chiropractor authorized to practice in the State and performing with the scope of their practice, meaning authorized to diagnose and treat physical or mental health conditions (treatment by a chiropractor is limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist); or
3. A nurse practitioner, nurse-midwife, clinical social workers or a physician's assistant authorized to practice under State law and performing within the scope of their practice, meaning authorized to diagnose and treat physical or mental conditions; or
4. A Christian Science practitioner listed with the First Church of Christ, Scientist in Boston, Massachusetts; or
5. Any health care provider recognized by the employer or the employer's group health plan's benefits manager; and,
6. A health care provider listed above who practices in a country other than the United States and who is authorized to practice under the laws of that country.

B. **"Incapacity"** is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery there from.

C. **"Regimen of Continuing Treatment"** includes, for example, a course of prescription medication (e.g., antibiotics) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over- the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

D. **"Serious Health Condition"** is an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. Any period of incapacity or treatment connected with Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or any subsequent treatment in connection with such inpatient care; or
2. Any period of incapacity of more than three consecutive calendar days from work, school, or other regular daily activities that also involves continuing treatment by (or under the supervision of) a health care provide; or
3. Any period of incapacity due to pregnancy, or for prenatal care; or
4. Any period of incapacity (or treatment therefore) due to a chronic serious health condition (e.g., asthma, diabetes, epilepsy); or
5. A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective (e.g., Alzheimer's, severe stroke, terminal stage of a disease); or,
6. Any absences to receive multiple treatments (including any period of recovery there from) by, or on referral by, a health care provider for a condition that likely would result in incapacity of more than if left untreated (e.g., chemotherapy, physical therapy), dialysis, etc.).

E. **"Treatment"** includes examinations to determine if a serious health condition exists and evaluations of the condition. It does not include routine examinations.