Family and Medical Leave Act of 1993 (FMLA)
Certification of Health Care Provider for Employee’s Serious Health Condition

SECTION I: For Completion by the EMPLOYER:

Employer contact: __________________________________________________________________

Employee’s job title: ________________________________________________________________________

SECTION II: For Completion by the 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. 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. 20 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).

Your name: __________________________________________________________________________________

First                                        Middle                                    Last

SECTION III: For Completion by the 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 and 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 treatments and expected duration of treatment: 

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: 

3. 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 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 QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

Signature Health Care Provider                                                   Date