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

SECTION I: For Completion by the EMPLOYER:

Employer contact: ______________________________________________________________________________

SECTION II: For Completion by the 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. 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 to your employer. 29 C.F.R. § 825.305.

Your name: __________________________________________________________________________________

First                          Middle                          Last

Name of the 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 amount of leave needed to provide care:

_______________________________________________________________________________________________

_______________________________________________________________________________________________

________________________________________________________________________________________________________

_______________________________________________________________________________________________

________________________________________________________________________________________________________

_______________________________________________________________________________________________

_______________________________________________________________________________________________

_______________________________________________________________________________________________

_______________________________________________________________________________________________

Employee Signature  ___________________________            ______________________________

Date
SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the 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 and business address: ________________________________________________________________

Type of practice/medical specialty: ________________________________________________________________

Telephone: (________)____________________________ Fax:(________)_______________________________

PART A: MEDICAL FACTS

1. 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: ____________________________________________________

   Was medication, other than over-the-counter medication, prescribed?  ___ No  ___Yes.

   Will the patient need to have treatment visits at least twice per year due to the condition?  ___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. 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 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.

   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 Health Care Provider                                                          Date