

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

Employer name and contact: \_\_\_\_\_

Employee's job title: \_\_\_\_\_ Regular work schedule: \_\_\_\_\_

Employee's essential job functions: \_\_\_\_\_

Check if job description is attached.

**SECTION I: For Completion by the EMPLOYEE**

**Instructions to the employee:** Please complete Section I before giving this form to your medical provider. The Family and Medical Leave Act (FMLA) permits an employer to require that you submit timely, complete, and sufficient medical certification to support a request for FMLA 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 II: 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

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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 (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:

\_\_\_\_\_  
\_\_\_\_\_

