



Division of Human Resources

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

SECTION I (To be completed by Employee)

Complete the following questions 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.

Employee's Name: _____ Employee ID#: _____

School/Dept.: _____ Position Title: _____

Signature of Employee

Date

SECTION II (To be completed by the Health Care Provider)

Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts listed below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc.

Health Care Provider Name: _____

Type of Practice/Medical Specialty: _____

Business Address: _____

Telephone Number: _____ FAX Number: _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced _____ Probable duration of condition _____

Mark below as applicable:

Was the patient admitted to an overnight stay in a hospital, hospice, or residential medical care facility? [] Yes [] No

Will the patient need to have treatment visits at least twice per year due to the condition? [] Yes [] No

Was medication, other than over-the-counter medication, prescribed? [] Yes [] No

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g. physical therapist)? [] Yes [] No. If yes, state the nature of such treatments and expected duration of treatment:

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

PART A: MEDICAL FACTS (continued)

3. Based on the job description provided or the employee's own description of his/her job functions, is the employee unable to perform any of his/her job functions due to this condition? Yes No If yes, identify the job functions the employee is unable to perform.

4. Describe the serious medical condition for which the employee seeks leave.

PART B: AMOUNT OF CARE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to the medical condition, including any time for treatment and recovery? Yes No

Estimate the beginning date _____ and ending date _____ for the period of Incapacity.

If leave estimated date cannot be determined, provide us the date of the next evaluation: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time on a reduced schedule because of the employee's medical condition? Yes No

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

Estimate the treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period.

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing required job functions? Yes No

Is it medically necessary for the employee to be absent from work during the flare-ups? Yes No

If yes, please 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 incur over the next six (6) months (e.g., episode every three (3) months lasting 1-2 days).

Frequency: ____ times per ____ week(s) ____ months(s) Duration: ____ hours or ____ day(s) per episode

ADDITIONAL INFORMATION (Identify question number with your additional response)

Signature of Health Care Provider

Date