

FAMILY MEDICAL LEAVE MEDICAL CERTIFICATION STATEMENT**EMPLOYEE'S OWN SERIOUS HEALTH CONDITION**

INSTRUCTIONS: Please complete Section 1 and then provide it to your healthcare provider. Section 2 must be completed by the treating healthcare provider. **PLEASE PRINT CLEARLY AND DO NOT USE WHITE OUT** because if the document is not legible or appears altered, it will delay processing your request or result in a denial.

The Family and Medical Leave Act (FMLA) permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for an absence that may qualify as FMLA leave due to your own serious health condition. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee at least 15 calendar days to provide the certification. If the employee fails to provide complete and sufficient medical certification, FMLA leave request may be denied. 29 C.F.R. § 825.313.

NOTE: JANUARY OF EVERY YEAR WILL BE CONSIDERED A NEW CERTIFICATION PERIOD

Section 1: To be completed by the EMPLOYEE

Employee name: (First) _____ (Middle) _____ (Last) _____

Employee's Address _____ City/State _____ Zip code _____

Employee's Job Title _____ Work Schedule: Shift _____ Days _____

Employee's Telephone (____) _____ Email _____ Date of Birth _____ (mm/dd/yyyy)

I certify that the information above is true, accurate and complete. I understand that requesting accommodation using false or incomplete information is fraud, which may result in disciplinary action.

Employee Signature _____ **Date** _____

Section 2: To Be Completed by the HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section and sign the form below. A family member of your patient has requested leave under the FMLA to care for your patient. The FMLA allows an employer to require that the employee submit a timely, complete and sufficient medical certification to support a request for FMLA leave to care for a family member with a serious health condition.

Health Care Provider's business address: _____

Type of practice / Medical specialty: _____

License # _____ National Provider Identifier (NPI) _____

Telephone: _____ Fax: _____ E-mail: _____

Describe the **specific medical facts which support your certification**, including a brief statement as to how the medical facts meet the criteria of one of these categories:

MEDICAL INFORMATION

Limit your response to the medical condition(s) for which the employee is seeking FMLA leave. Your answers should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Note: For FMLA purposes, "incapacity" means the inability to work or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. 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 family members of employee, 29 C.F.R. § 1635.3(b).

1. Serious Health Condition is an illness, injury, impairment or physical or mental condition that involves inpatient care or continuing treatment by a health care provider. 29 C.F.R. § 825.113(a). Does your patient's condition qualify under any one of the categories described below? If so, check the applicable category:
 - (A) ☐ **Inpatient Care:** An overnight stay in a hospital, hospice or residential medical care facility. Including any period of incapacity or any subsequent treatment in connection with the overnight stay.
 - (B) ☐ **Incapacity Plus Treatment:** A period of incapacity of more than three consecutive, full calendar days and any subsequent treatment or period of incapacity relating to the same condition, that also involves either:
 1. Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exists. The first visit must be within seven days of the first day of incapacity; or
 2. At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health care provider might prescribe a course of prescription medication or therapy requiring special equipment.
 - (C) ☐ **Pregnancy:** Any period of incapacity due to pregnancy or for prenatal care.
 - (D) ☐ **Chronic Condition:** Any period of incapacity due to or treatment for a chronic serious health condition such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
 - (E) ☐ **Permanent/Long-Term Condition Requiring Supervision:** A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider such as Alzheimer's disease or the terminal stages of cancer.
 - (F) ☐ **Multiple Treatments (Non-Chronic Conditions):** Restorative surgery after an accident or other injury; or a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.
 - (G) ☐ None of the above

PLEASE ONLY COMPLETE THE EVENT(S) THAT APPLY

	SINGLE EVENT
I.	Due to this condition, will employee need a continuous period, including any time for treatment(s) and/or recovery? Yes _____ No _____ If yes provide: beginning date _____ (mm/dd/yy) return to work date _____ (mm/dd/yy)
	INTERMITTENT (Flare-up)
II.	Due to this condition is it medically necessary for employee to be absent from work due to flare-ups? Yes _____ No _____ Frequency: _____ episodes per _____ week(s) Duration: _____ hours or _____ day (s) per episode or Estimated days per month (should equal the recommended frequency and duration) _____
	INTERMITTENT (Medical Treatment)
III.	Due to this condition, will the employee periodically be unable to work due to planned medical treatment(s) (e.g. physical therapy, office visits)? Yes _____ No _____ Frequency: _____ appointment(s) per _____ week/month Duration: _____ hours per appointment Estimated days per month (should equal the recommended frequency and duration) _____ You are required to provide adequate advanced notice to your supervisor (ideally 30 days) prior to each appointment.
	REDUCED
IV.	Due to this condition, is it medically necessary for the employee to work a <i>reduced work week schedule</i>? Yes _____ No _____ beginning reduced work date _____ (mm/dd/yy) return to full work schedule date _____ (mm/dd/yy) Work Days Per Week: _____ Hours Per Work Day: _____

By providing my signature, I certify that the information is true, accurate and all alterations are initialed by provider.

Health Care Provider Print Name _____

Health Care Provider Signature _____ **Date Form Completed** _____