Instructions for Employee & Health Care Provider

Instructions for Employee

- Please give the attached Certification for Health Care Provider form to your family member or their health care provider
- Failure to provide a complete and sufficient medical certification may result in the denial of your FMLA request
- You must return the completed Certification for Health Care Provider form (or a sufficient alternative) within 15 calendar days
- The due date for the return of completed Certification for Health Care Provider form is listed at the top of the certification and on the Notice of Eligibility letter given to you by your department's HR Liaison

Instructions for Health Care Provider

- Answer, fully and completely, all applicable parts of the attached Certification for Health Care Provider form
- Terms such as "**lifetime**," "**unknown**," "**ongoing**," and "**to be determined**" may not be sufficient to determine FMLA coverage
- If information such as end dates are not yet determined, you may use a follow up appointment date
- If information such as the frequency and/or duration of treatment/appointments and/or episodes of incapacity are not yet known, please use your medical expertise and knowledge of the patient's condition to provide a best estimate
- You may revise your estimate of treatment/appointments and/or episodes of incapacity at any time
- A medical diagnosis is **NOT** required
- Limit your responses to the condition for which the employee is seeking leave
- 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
- If multiple unrelated conditions exist **and** require leave, those conditions will each require a separate certification on a separate form (please specify which form pertains to each condition; conditions may be numbered to differentiate if so desired: Condition 1, Condition 2, etc.)
- Do **NOT** provide information about genetic tests, genetic services, of the manifestation of disease or disorder in the employee's family members
- Please be sure to sign the form on the last page
- **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION**

FMLA Certification for Health Care Provider

Patient Name:	Employee work schedule:
Patient Date of Birth:	Requested Frequency:
Employee's Name:	Paperwork Due Date:

PART A: MEDICAL FACTS

OPTIONAL – List any relevant medical facts related to the condition for which the patient needs care. Such facts may include symptoms, continued regimen of treatment, use of specialized equipment, or diagnosis:

_____

REQUIRED – Mark below as applicable:

☐ Admitted for an overnight stay in a hospital, hospice, or residential medical care facility

Dates of admission: _____

☐ Permanent or long-term condition for which treatment may not be effective
(e.g., Alzheimer's disease, stroke, terminal illness, etc.)

☐ Out of work to undergo multiple treatment/appointments and related recovery therefrom, by or on referral by, a health care provider for either:

a) A restorative surgery from an injury or illness

OR

b) A condition that likely would result in incapacity of greater than three (3) full, consecutive calendar days if left untreated

☐ Incapacity for more than three (3) full, consecutive, calendar days **AND** at least one (1) of the following (Choose one of the below):

☐ Two (2) or more treatment/appointments with a healthcare provider within the first thirty (30) days of certified incapacity

Dates of treatment/appointments: _____

OR

☐ At least one (1) treatment/appointment with a healthcare provider within the first seven (7) days of certified incapacity **AND** a continued regimen of care
(e.g., R/x medication, physical therapy, referral to another provider for care, etc.)

Date(s) of treatment/appointment(s): _____

Continued regimen of care: _____

☐ Chronic condition which continues over an extended period of time **AND**

1. Requires periodic visits to a healthcare provider – at least two (2) per year
2. May cause episodic periods of incapacity

(e.g., asthma, diabetes, epilepsy, etc.)

☐ Pregnancy/Maternity and/or related conditions (Complete the below **required** information)

Estimated Date of Delivery: _____ ***(MM/DD/YYYY)***

Confirmed Date of Delivery (if known): _____ ***(MM/DD/YYYY)***

Complications: _____

☐ None of the above criteria apply to the patient's condition. The patient does not have a serious health condition as defined by the FMLA. An additional follow up for confirmation may be requested.

Limit your responses to the condition for which the employee is seeking leave. 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 employee's family members, 29 C.F.R. §1635.3(b).

Patient Name:
Patient Date of Birth: Paperwork Due Date:

PART B: AMOUNT OF LEAVE NEEDED

☐ **Continuous Leave:** Will the patient be incapacitated and require care from their family member for a single continuous period of time due to their medical condition, including any time for treatment and recovery? ☐ **YES |** ☐ **NO**

If yes: Estimated Start Date _____ ***(MM/DD/YYYY)***

Estimated End Date _____ ***(MM/DD/YYYY)***

A follow up appointment date may be used if end date is unknown

Will the employee require intermittent leave or reduced schedule to care for the patient? If so, complete the relevant sections below.

☐ **Intermittent Leave:**

Start date/initial appointment date: _____ ***(MM/DD/YYYY)***
Estimated end date: _____ ***(MM/DD/YYYY)*** **|** ☐ **Lifelong**

- Will the patient require follow-up treatments, including time for recovery? ☐ **YES |** ☐ **NO**

Estimated treatment/appointment schedule:

Up to _____ per **DAY | WEEK | MONTH | YEAR** ***(circle one)***

EACH lasting up to _____ hours **OR** _____ days (including recovery and commute)
Future treatment/appointment dates: _____

_____

- Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ☐ **YES |** ☐ **NO**

Estimated frequency & duration of episodes/flares:

Up to _____ per **DAY | WEEK | MONTH | YEAR** ***(circle one)***

EACH lasting up to _____ hours **OR** _____ days

Dates you have already treated the patient for this condition:

_____

_____

☐ **Reduced Schedule:**

Start Date: _____ ***(MM/DD/YYYY)***
End Date: _____ ***(MM/DD/YYYY)***

Review and answer the below based upon the employer-provided work schedule or the employee's own description of their typical work schedule if none provided.

Provide the days and number of hours the employee **CAN** work *(not to include their lunch break).* If the employee is to be scheduled off, please indicate below.

SUNDAY _____ hours **|** ☐ OFF

MONDAY _____ hours **|** ☐ OFF

TUESDAY _____ hours **|** ☐ OFF

WEDNESDAY _____ hours **|** ☐ OFF

THURSDAY _____ hours **|** ☐ OFF

FRIDAY _____ hours **|** ☐ OFF

SATURDAY _____ hours **|** ☐ OFF

Notes:

REQUIRED – Health Care Provider Contact & Signature:

Provider's Printed Name & Credentials:

Provider Address:

Provider Signature:

Provider Telephone #:

Date:

Provider Fax #:

Type of Practice/Specialty:

Limit your responses to the condition for which the employee is seeking leave. 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 employee's family members, 29 C.F.R. §1635.3(b).