SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee’s health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer name and contact:

________________________________________________________________________________________

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your 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 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

Name of family member for whom you will provide care: ______________________________________

Relationship of family member to you: ____________________________________________________

First Middle Last

If family member is your son or daughter, date of birth: _________________________________

Describe care you will provide to your family member and estimate leave needed to provide care:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Employee Signature Date
SECTION III: For Completion by the HEALTH CARE PROVIDER

*The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. Genetic information, as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

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.

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 employee seeks leave (such 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

4. 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.

   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.

________________________________________________________________________

________________________________________________________________________

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________________________________________________________________________

Signature of Health Care Provider  Date

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210.

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.