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Certification of Health Care Provider for Employee's Serious Health Condition under the Family and Medical

2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee at leas

fails to provide complete and sufficient medical certification, his or her FMLA le

about the FMLA may be found on the WHD website at www.dol.gov/agencies/wh

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. You may not ask the emr (s)-T (c)-3 (h)0.7 (i)-1 (s)-t9(i)-1y(h <</MC(c)-3MC(c)-33 (e)-7 (2 <</t9(i)-13 (e)-7p (t)-3r)ask)t9(i)-1v47 e825.308(c) [illegible] (h u)t9(i)-1r)0 not request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, 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, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

(1) Employee name: ____
First Middle Last

(2) Employer name: ______________________________ Date: ______________ (mm/dd/yyyy)
(List date certification requested)

(3) The medical certification must be returned by ______________________ (mm/dd/yyyy)
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

(4) Employee's job title: ______________________________ Job description ☐ is / ☐ is not attached.

Employee's regular work schedule: ______________________________

Statement of the employee's essential job functions:

____

(The essential functions of the employee's position are determined with reference to the position the employee held at the time the employee notified the employer of the need for leave or the leave started, whichever is earlier.)

SECTION II - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient has requested leave under the FMLA. 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 due to the serious health condition of the employee. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves inpatient care or continuing treatment by a health care provider . For more information about the definitions of a serious health condition under the FMLA, see the chart on page 4.

You also may, but are not required to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of cont inuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

Employee Name: _____

Health Care Provider's name: (Print) _____

Health Care Provider's business address: _____

Type of practice / Medical specialty: _____

Telephone: _____ Fax: _____ E-mail: _____

PART A: 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. After completing Part A, complete Part B to provide information about the amount of leave needed. Note: For FMLA purposes, "incapacity" means the inability to work, attend school, 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 employee's family members, 29 C.F.R. § 1635.3(b).

(1) State the approximate date the condition started or will start: _____ (mm/dd/yyyy)

(2) Provide your best estimate of how long the condition lasted or will last: _____

(3) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

Inpatient Care: The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s):

Incapacity plus Treatment : (e.g. outpatient surgery, strep throat)

Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for more than three consecutive, full calendar days from: _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy).

The patient (☐ was / ☐ will be) seen on the following date(s):

_____

The condition (has / has not) also resulted in a course of continuing treatment under the supervision of a health care provider (e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment).

Pregnancy: The condition is pregnancy. List the expected delivery date: _____ (mm/dd/yyyy).

Chronic Conditions : (e.g. asthma, migraine headaches) Due to the condition, it is medically necessary for the patient to have treatment .26 0 Td [(o EMC uMC uMC uMC uMC uMC uMC uMC uMC Dt7d ( )Tj -0.003 Tc 0.0031.6 (m)-1.6 (/dd/y)-3.72.7 (re)2.33.4 (a,

Employee Name: _____

(4) If needed, briefly describe other appropriate medical facts related to the condition(s) for w Tc -0 Tcw ( )T .023 01 0 l S6Tc 0T /TT1 12c 0.003 T5 6.

Employee Name: _____

PART C: Essential Job Functions

If provided, the information in Section I question #4 may be used to answer this question. If the employer fails to provide a statement of the employee's essential functions or a job description, answer these questions based upon the employee's own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be not able to perform the essential job functions of the position during the absence for treatment(s).

(10) Due to the condition, the employee (was not able / is not able / will (QeTc 0 i(Q(i)-Pw EMC /P <</MCID 12 >>BDC e