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

# U.S. Department of Labor Wage and Hour Division



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

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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. 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, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

#### **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 employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Additionally, you may 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 r	equested)
(3) The medical certification	must be returned by			(mm/dd/yyyy)
(Must allow at least 15 cal	endar days from the date reques	ted, unless it is not feasible despite the	e employee's diligent, good faith eff	orts.)
(4) Employee's job title:			Job description  is	/ is not attached.
Employee's regular work	schedule:			
Statement of the employ	ee's essential job functions:			
`	the employee's position are dete	ermined with reference to the position the	ne employee held at the time the en	nployee notified the

#### **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 continuing 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 add	ress:	
Type of practice / Medical specialty:		
Telephone:	Fax:	E-mail:
PART A: Medical Information		
based upon your medical knowled information about the amount of regular daily activities due to the co	ge, experience, and exan leave needed. Note: For F ndition, treatment of the c 85.3(f), genetic services, a	employee is seeking FMLA leave. Your answers should be your <b>best estima</b> nination of the patient. <b>After completing Part A, complete Part B to provio</b> FMLA purposes, "incapacity" means the inability to work, attend school, or perforondition, or recovery from the condition. Do not provide information about genes defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder
(1) State the approximate date the o	condition started or will sta	rt: (mm/dd/yyyy)
(2) Provide your <b>best estimate</b> of ho	ow long the condition laste	d or will last:
(3) Check the box(es) for the question	ons below, as applicable. F	For all box(es) checked, the amount of leave needed must be provided in Part B.
		pected to be) admitted for an overnight stay in a hospital, wing date(s):
Incapacity plus Treatment		
Due to the condition, the pa	tient (  has been /	is expected to be) incapacitated for more than three
consecutive, full calendar da	ays from:	(mm/dd/yyyy) to (mm/dd/yyyy).
The patient ( was /	will be) seen on the follow	ving date(s):
		n a course of continuing treatment under the supervision of a er than over-the-counter) or therapy requiring special equipment).
Pregnancy: The condition is	pregnancy. List the exp	pected delivery date: (mm/dd/yyyy).
Chronic Conditions: (e.g. a treatment visits at least twice		es) Due to the condition, it is medically necessary for the patient to have
		er's, terminal stages of cancer) Due to the condition, incapacity is permanent f a health care provider (even if active treatment is not being provided).
Conditions requiring Multinecessary for the patient to		motherapy treatments, restorative surgery) Due to the condition, it is medically s.
None of the above: If none needed. Go to page 4 to sig		vere checked, (i.e., inpatient care, pregnancy) no additional information is

Employee Name:
(4) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. (e.g., use of nebulizer, dialysis)
PART B: Amount of Leave Needed
For the medical condition(s) checked in Part A, complete all that apply. Several questions seek a response as to the frequency or duration of condition, treatment, etc. Your answer should be your <b>best estimate</b> 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.
(5) Due to the condition, the patient (  had /  will have) planned medical treatment(s) (scheduled medical visits)  (e.g.psychotherapy, prenatal appointments) on the following date(s):
(6) Due to the condition, the patient ( was / will be) referred to other health care provider(s) for evaluation or treatment(s).
State the nature of such treatments: (e.g. cardiologist, physical therapy)
Provide your <b>best estimate</b> of the beginning date (mm/dd/yyyy) and end date (mm/dd/yyyy).
for the treatment(s).
Provide your <b>best estimate</b> of the duration of the treatment(s), including any period(s) of recovery (e.g. 3 days/week)
(7) Due to the condition, it is medically necessary for the employee to work a <b>reduced schedule</b> .
Provide your <b>best estimate</b> of the reduced schedule the employee is able to work. From (mm/dd/yyyy)
to (mm/dd/yyyy) the employee is able to work: (e.g., 5 hours/day, up to 25 hours a week)
(8) Due to the condition, the patient ( was / will be) incapacitated for a continuous period of time, including any time
for treatment(s) and/or recovery.
Provide your <b>best estimate</b> of the beginning date (mm/dd/yyyy) and end date (mm/dd/yyyy).
for the period of incapacity.
(9) Due to the condition, it ( was / is / will be) medically necessary for the employee to be absent from work on an
intermittent basis (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your <b>best estimate</b> of how often (frequency) and how long (duration) the episodes of incapacity will likely last.
Over the next 6 months, episodes of incapacity are estimated to occur times per
( day week month) and are likely to last approximately ( hours days) per episode

Employee Name:		
PART C: Essential Job Functions		
If provided, the information in Section I question #4 may be used to ansemployee's essential functions or a job description, answer these quest functions. An employee who must be absent from work to receive medic condition is considered to be <b>not able</b> to perform the essential job function	ions based upon the employee's own description al treatment(s), such as scheduled medical visits,	of the essential joint for a serious healt
(10) Due to the condition, the employee (  was not able /  is not ab	ole / will not be able) to perform <b>one or more</b> o	of the
essential job function(s). Identify at least one essential job function the em	iployee is not able to perform:	
Signature of Health Care Provider	Date:	(mm/dd/yyyy
Definitions of a Serious Health Condition (See 29 C.F.R. §§ 825	.113115)	
Inpatient Care		
<ul> <li>An overnight stay in a hospital, hospice, or residential medical</li> <li>Inpatient care includes any period of incapacity or any subseq</li> </ul>	•	nt stay.
Continuing Treatment by a Health Care Provider (any one or m	ore of the following)	
Incapacity Plus Treatment: A period of incapacity of more than the treatment or period of incapacity relating to the same condition, that	at also involves either:	·
o Two or more in-person visits to a health care provider fo extenuating circumstances exist. The first visit must be v	•	•
o At least one in-person visit to a health care provider for t results in a regimen of continuing treatment under the si provider might prescribe a course of prescription medical	upervision of the health care provider. For exa	
Pregnancy: Any period of incapacity due to pregnancy or for pren	atal care.	
<b>Chronic Conditions</b> : Any period of incapacity due to or treatment asthma, migraine headaches. A chronic serious health condition is supervised by the provider) at least twice a year and recurs over a episodic rather than a continuing period of incapacity.	one which requires visits to a health care prov	vider (or nurse
<b>Permanent or Long-term Conditions</b> : A period of incapacity whit treatment may not be effective, but which requires the continuing stages or the terminal stages of cancer.		
Conditions Requiring Multiple Treatments: Restorative surgery	after an accident or other injury; or, a condition	on that would

### 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 15 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 Avenue, N.W., Washington, D.C. 20210.

likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.