Certification of Health Care Provider for Employee's Serious Health Condition

(Extended Leave, FMLA, and JPAL)

Phone: 410-222-5090 Fax: 443-458-0140

SECTION I: Completed by the Employee

Please complete this section 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. ***Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request.*** Your employer must give you at least 15 calendar days to return this form.

Employee Name (First, Middle Last)	Employee Title

Regular Work Schedule	Birthdate

Essential Job Functions

Check if job description is attached ☐

SECTION II: Completed by 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. 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).

Provider's Name	Provider's Business Address	
Type of Practice/ Medical Specialty	Phone	Fax

Signature of Health Care Provider Date

PART A: Medical Facts

1. Approximate date condition commenced: _____ Probable duration of condition: _____

   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 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. Use the information provided in Section I. *If a list of the employee's essential functions or a job description is unavailable, answer based upon the employee's own description of his/her job functions.*

   Is the employee unable to perform any of his/her job functions due to the condition: _____ No _____ Yes.

   If so, identify the job functions the employee is unable to perform:

   _____

   _____

   _____

Continued on next page

4. 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

5. 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

   If so, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___No ___Yes

   If so, are the treatments or the reduced number of hours of work medically necessary? ___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:

   Estimate the part-time or reduced work schedule the employee needs, if any: _____hour(s) per day; _____ days per week from _____ through _____.

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ___No ___Yes

   Is it medically necessary for the employee to be absent from work during the flare-ups? ___No ___Yes.

   If so, explain: _____

   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

ADDITIONAL INFORMATION: Identify Question Number With Your Additional Answer.

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, DC20210. DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT