Certification of Health Care Provider for Family Member'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 family member or his/her 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 to care for a covered family member with a 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 to your employer.

Employee Name (First, Middle Last)

Name of family member for whom you will provide care (First, Middle Last)	Relationship of family member to you:	If family member is a son or daughter, date of birth:

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

____

____

Employee Signature Date

SECTION II: Completed by the Health Care Provider

The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. 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 patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Page 3 provides space for additional information, should you need it.

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 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: ____________

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3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

PART B: Amount of Care Needed

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.

4. Will the patient 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: ______________________________

   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 ___________ (*date*) through ___________ (*date*).

   Explain the care needed by the patient, and why such care is medically necessary:

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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:

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ADDITIONAL INFORMATION: Identify Question Number With Your Additional Answer.

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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