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

U.S. Department of Labor Wage 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 leave to care for a family member with a serious health condition to submit a medical certification issued by the family member'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 <u>may not</u> 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' family members 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.

	First	Middle	Last	
(2) Employer name:			Date:	(mm/dd/yyyy)
			(List date certifi	cation requested)
(3) The medical certification (Must allow at least 15 ca	on must be returned by lendar days from the date	requested, unless it is not f	easible despite the employee's diligent	(mm/dd/yyyy) t, good faith efforts.)
	S	ECTION II - EMPI	LOYEE	
for FMLA leave due to the to obtain or retain the bene medical certification is pro	serious health condition fit of the FMLA protect vided to your employed Failure to provide a c	n of your family member etions. 29 U.S.C. §§ 261 er within the time frame	ete, and sufficient medical certificate, and sufficient medical certificate. If requested by your employer, y 3, 2614(c)(3). You are responsible requested, which must be at lead nedical certification may result in	your response is required ble for making sure the ast 15 calendar days. 29
(1) Name of the family m	ember for whom you v	vill provide care:		
(2) Select the relationship	of the family member	to you. The family men	mber is your:	
☐ Spous	Par □ Par	rent \square	Child, under age 18	
☐ Child,	age 18 or older and in	capable of self-care bec	ause of a mental or physical disa	bility
Spouse means a husb	and or wife as define	d or recognized in the	state where the individual was	married, including in a

common law marriage or same-sex marriage. The terms "child" and "parent" include *in loco parentis* relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for an individual who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a child for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.

(1) Employee name:

En	ployee Name:
(3)	Briefly describe the care you will provide to your family member: (Check all that apply) ☐ Assistance with basic medical, hygienic, nutritional, or safety needs ☐ Physical Care ☐ Psychological Comfort ☐ Other:
(4)	Give your best estimate of the amount of leave needed to provide the care described:
(5)	If a reduced work schedule is necessary to provide the care described, give your best estimate of the reduced schedule you are able to work. From (mm/dd/yyyy) to (mm/dd/yyyy), I am able to work (hours per day) (days per week).
	pployee gnature Date (mm/dd/yyyy)
	SECTION III - HEALTH CARE PROVIDER
hea tha hea Yo	mely, complete, and sufficient medical certification to support a request for FMLA leave to care for a family member with a serious alth condition. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition to involves inpatient care or continuing treatment by a health care provider. For more information about the definitions of a serious alth condition under the FMLA, see the chart at the end of the form. The provider is a serious including symptoms, diagnosis, or any regimen of attinuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of wate medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.
Не	alth Care Provider's name: (Print)
Не	alth Care Provider's business address:
Ty	pe of practice / Medical specialty:
Tel	lephone: () Fax: () E-mail:
<u>PA</u>	RT A: Medical Information
bes Par wo Do or t	mit your response to the medical condition for which the employee is seeking FMLA leave. Your answers should be your at estimate based upon your medical knowledge, experience, and examination of the patient. After completing Part A, complete at B to provide information about the amount of leave needed. Note: For FMLA purposes, "incapacity" means the inability to rk, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. 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), the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).
	Patient's Name:
	State the approximate date the condition started or will start:
(3)	Provide your best estimate of how long the condition lasted or will last:
(4)	For FMLA to apply, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient (e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort).

Emp.	ioyee r	vame:
		the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be ed in Part B.
		<u>Inpatient Care</u> : 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 (\square has / \square 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).
		<u>Chronic Conditions</u> : (e.g. asthma, migraine headaches) Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.
		<u>Permanent or Long Term Conditions</u> : (e.g. Alzheimer's, terminal stages of cancer) Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).
		<u>Conditions requiring Multiple Treatments</u> : (e.g. chemotherapy treatments, restorative surgery) Due to the condition, it is medically necessary for the patient to receive multiple treatments.
		None of the above: If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.
		ed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks leave. (e.g., use of nebulizer, dialysis)
- PAR	T B: 4	Amount of Leave Needed
of a exam	conditi ination	ical condition(s) checked in Part A, complete all that apply. Several questions seek a response as to the frequency or duration on, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to the benefits and protections of the FMLA apply.
(7)		to the condition, the patient (\square had / \square will have) planned medical treatment(s) (scheduled medical visits) (e.g. otherapy, prenatal appointments) on the following date(s):
(8)		to the condition, the patient (\square was / \square will be) referred to other health care provider(s) for evaluation or ment(s).
	State	the nature of such treatments: (e.g. cardiologist, physical therapy)
		ide your best estimate of the beginning date (mm/dd/yyyy) and end date (d/yyyy) for the treatment(s).
	Provi	ide your best estimate of the duration of the treatment(s), including any period(s) of recovery (e.g. 3 days/week)

Emp	loyee Name:
(9)	Due to the condition, the patient (\square was / \square will be) incapacitated for a continuous period of time , including any time for treatment(s) and/or recovery.
	Provide your best estimate of the beginning date: (mm/dd/yyyy) and end date (mm/dd/yyyy) for the period of incapacity.
(10)	Due to the condition it, (\square was / \square is / \square will be) medically necessary for the employee to be absent from work to provide care for the patient on an intermittent basis (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your best estimate 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.
	gnature of lath Care Provider Date (mm/dd/yyyy)
	Definitions of a Serious Health Condition (See 29 C.F.R. §§ 825.113115)
	Inpatient Care
•	An overnight stay in a hospital, hospice, or residential medical care facility. Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.
	Continuing Treatment by a Health Care Provider (any one or more of the following)
	apacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment eriod of incapacity relating to the same condition, that also involves either:
	 Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
Pre	gnancy: Any period of incapacity due to pregnancy or for prenatal care.
mig the	conic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, raine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a tinuing period of incapacity.
	manent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which tment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease

or the terminal stages of cancer.

Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

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.