pennsylvania

Family and Medical Leave Act
Employee Serious Health Condition Certification

SECTION 1: TO BE COMPLETED BY EMPLOYEE

INSTRUCTIONS: Please complete Section 1 and then provide it to your health care provider. Section 2 must be completed by the treating health care provider; it is inappropriate for you to complete section 2.

The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for an absence that may qualify as FMLA leave due to your own serious health condition. 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.

If this is a request for leave to care for a family member or next of kin, do not use this form; obtain the correct form from your human resources office.

Employee Name	Personnel Number

Agency	Work Location

Is this condition the result of a work-related injury?

☐ No ☐ Yes

SECTION 2: TO BE COMPLETED BY HEALTH CARE PROVIDER:

INSTRUCTIONS: The above employee 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 on 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 response to the condition for which the employee is seeking leave. **Please sign the last page.**

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. None of the questions on this form require genetic information.

Supporting Medical Certification:

1. Approximate date condition commenced	2. Probable duration of condition (Example: 3 months, 1 year, etc.)
3. Approximate date **incapacity*** commenced	4. Date(s) you treated patient for condition

5. Was patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

☐ No ☐ Yes If yes, please list most recent date of admission _____ and discharge _____

6. Will the patient need to have treatment visits at least twice per year due to the condition?

☐ No ☐ Yes

7. Was medication, other than over-the-counter medication, prescribed?

☐ No ☐ Yes

8. Was the patient referred to another health care provider(s) for evaluation or treatment (example: physical therapist)?

☐ No ☐ Yes If yes, state the nature of such treatments and expected duration of treatment.

9. Is the medical condition pregnancy?

☐ No ☐ Yes If yes, expected delivery date is _____.

10. Using the attached job description or essential functions as a guide, is patient able to perform all of his/her job functions?

☐ No ☐ Yes If no, which functions cannot be performed due to this condition?

*Incapacity is the inability to work, attend school or perform other regular daily activities.

Employee Name _____ Personnel Number _____

Medical Facts:

11. Describe 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).

Amount of Care Needed

12. **Absences for Appointments -** Did or will employee need to attend medical treatments/appointments because of the medical condition? ☐ No ☐ Yes

    If yes, estimate the appointment schedule, if any. Include the dates of scheduled appointments and the time required for each appointment, including any recovery period.

    _____

    Can appointments be scheduled during non-work hours? ☐ No ☐ Yes

13. **Continuous Absence -** Did or will employee be incapacitated for a single continuous period of time due to the medical condition, including any time for treatment and recovery? ☐ No ☐ Yes

    If yes, specify the **begin date** _____ AND **end date** _____ of the period of incapacity.

14. **Absences on an Intermittent or Part-time Basis.**

    Did or will condition cause episodic flare-ups on an INTERMITTENT basis (sporadic, unpredictable in nature) preventing the employee from performing his/her job functions? ☐ 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 patient may have during the probable duration (see Question 2). (**Example:** 1 episode every month lasting 1-2 days in duration).

    Frequency: Number of times ____ per week; OR Number of times ____ per month

    Duration: Number of hours ____ per episode; OR Number of days ____ per episode

    _____

    Did or will employee need to work on a PART-TIME basis (set, recurring schedule) due to the medical condition? ☐ No ☐ Yes

    If yes, specify the **begin date** _____ AND **end date** _____ of the part-time basis.

    Estimate the hours the employee needs to work on a part-time basis.
    Hours per day: _____ Days per week: _____

By providing my original signature, the undersigned health care provider certifies that the information is true and accurate.

Printed Name of Health Care Provider	Type of Practice/Medical Specialty	License Number
Address		Telephone Number
Name and Title of Staff Member (if form not completed by the Health Care Provider)		Fax Number
Signature of Health Care Provider		Date

Please return this form to the employee or to:

FMLA Specialist
HR Service Center - FMLA
PO Box 824
Harrisburg, PA 17108-0824

Phone: 717.346.4667 Fax: 717.425.5389 Email: RA-SPFabsence@pa.gov