

Family and Medical Leave Act

Family Member Serious Health Condition Certification

SECTION 1: TO BE COMPLETED BY EMPLOYEE

INSTRUCTIONS: Please complete Section 1 and then provide it to your family member's health care provider. Section 2 must be completed by the treating health care provider; it is inappropriate for you or the family member 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 to care for a covered family member with a 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 an adult child, an *Adult Child Certification of Disability* must also be completed. If this is a request for leave for yourself or a serious injury or illness for a covered service member, do not use this form. Obtain these forms from your human resources office, if needed.

Employee Name		Personnel Number	
Agency		Work Location	
Family Member/Patient Name	Relationship to Employee	If Son/Daughter, Date of Birth	

Describe the care you will provide to your family member and estimate the amount of leave needed to provide this care; include a schedule, if possible for intermittent absences.

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.**

When answering **Amount of Care Needed** questions, **keep in mind the patient's need for care by the employee seeking leave**, which may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care.

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? <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes	
7. Was medication, other than over-the-counter medication, prescribed? <input type="checkbox"/> No <input type="checkbox"/> Yes	
8. Was the patient referred to another health care provider(s) for evaluation or treatment (example: physical therapist)? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, state the nature of such treatments and expected duration of treatment.	
9. Is the medical condition pregnancy? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, expected delivery date is _____.	

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

Medical Facts:

10. 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 (see instructions on page 1)

11. **Absences for Appointments** - Did or will the employee need to be absent to attend medical treatments/appointments with the patient 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

12. Continuous Absence.

Did or will the employee be required to provide care for the patient during a CONTINUOUS absence 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.

13. 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 patient from participating in normal daily activities and requiring the employee to provide care? 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 the employee be required to provide care for the patient on a PART-TIME basis (set, recurring schedule) including any time for recovery?

No Yes

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

Estimate the hours the employee is needed to care for patient on a part-time basis.

Hours per day: _____ Days per week: _____

14. **Type of Care Required** – Explain, in detail, the type of care that the employee will provide for the patient during any of the above noted absences and why such care is medically necessary.

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