Employee Section of Certification of Health Care Provider for **Family Member's** Serious Health Condition (Family and Medical Leave Act)

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Employee Section

Note: If the certification is not completed in English, the employee may be asked to furnish a translation.

INSTRUCTIONS to the EMPLOYEE: 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. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: <FirstName /> _____ <LastName />
First Middle Last

Name of family member for whom you will provide care:

_____
First Middle Last

Relationship of family member to you: _____

- If spouse, please provide the spouse's gender: ☐ Male ☐ Female
- If son or daughter, please provide the date of birth: _____

Describe the care you will provide to your family member: _____

_____

_____

_____

Estimate leave needed to provide care: _____

_____

_____

Indicate the documents included in your submission:

☐ Employee Section (this page only)

☐ Certification of Health Care Provider for Family Member's Serious Health Condition (pages 1 through 3)

☐ Permission to Contact Health Care Provider(s) (separate form provided in your packet)

☐ Certification of Health Care Provider Leave to Care for a Child Age 18 or Older (if applicable)

_____

Employee Signature **Date**

Leave # <NaviLinkLegacyClaimNbr />

Return completed form by mail or fax to: <CorporateBrand /> Leave Management Center, P.O. Box 100158, Columbia, SC 29202-3158; Fax: 866-249-3831 (International fax 423-294-1285); Phone: 866-779-1054.

Certification of Health Care Provider for **Family Member's** Serious Health Condition (Family and Medical Leave Act)

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PATIENT'S NAME: _____
FIRST MIDDLE LAST

Leave Requested By: <FirstName /> <LastName />

Note: If the certification is not completed in English, the employee may be asked to furnish a translation.

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient's family member has requested leave under the FMLA. Answer, fully and completely, all applicable parts, as missing information may cause delays. 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 your patient's family member is seeking leave. **Page 3 provides additional space should you need it.**

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. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic test, the fact that an individual or an individual's family member sought or received genetic services, and genetic information or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Medical Facts

1. Describe any relevant medical facts related to the condition for which the patient needs care (may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment). *In CT, do not disclose diagnosis without patient's consent*: _____
2. Approximate date symptoms/medical condition started: _____
3. Probable duration of medical condition: _____
4. Was the patient admitted for an inpatient stay to a hospital, hospice, or residential medical care facility? ____ Yes ____ No If yes, dates of admission: _____
5. Is the medical condition pregnancy? ___ Yes ___ No If yes, expected delivery date: _____

Dates/Types of Treatment(s)/Visit(s)

6. Date first seen for the *current* condition: _____
7. Provide the below information regarding treatment(s) *and/or* office visit(s):
   a. Date(s) of past treatment(s)/visit(s) for current condition: _____
   b. Date(s) of anticipated treatment(s)/visit(s) for current condition: _____
8. a. Indicate the estimated number of treatment(s)/visit(s), and/or estimated duration of medical treatment(s)/visit(s):
      - Estimated *treatment/visit schedule*: ____times **per** _____ week(s) ____month(s) ____year(s)
      - Estimated *recovery* for each *treatment/visit(s)*: ____hours or ____day(s) **per** treatment/visit

   b. Is it *medically necessary* for the patient to attend such treatment(s)/visit(s)? ____ Yes ____ No

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9. Is it necessary for the patient to have *two or more* treatment(s) and/or visit(s) per year due to the condition? ____ Yes ____ No
10. Was medication prescribed (excluding over-the-counter medication)? ____ Yes ____ No
11. Was the patient *referred to other health care provider(s)* for evaluation or treatment/visit (e.g., physical therapist)? ____ Yes ____ No

    Nature and estimated duration of treatment(s)/visit(s): _____

Limitation(s)/Care needed due to Condition (Past/Present/Future)

12. a. Does this condition cause a single ***full/continuous period of inability*** to perform daily activities, or attend school or work? ____Yes ____No

    b. Estimate the dates of the ***full/continuous period of inability****:*

    From _____ Through _____

13. Answer the following questions ***for care on an intermittent basis or a reduced work schedule***.

    Provide an estimated frequency and duration of each episodic flare-up and/or the reduced schedule

    a. **Episodic flare-up(s):**

    - Estimated *episode frequency*: ____ times **per** ____ week(s) ____ month(s) ____ year(s)
    - Estimated *episode duration*: ____ hours (or) ____ day(s) **per** flare up

    b. **Reduced schedule:** ____ hour(s) **per** day; ____ day(s) **per** week from: _____

14. Does the patient need ***care*** during the periods of treatment and inability to perform daily activities provided above (care may include basic medical, hygienic, nutritional, safety or transportation needs, or the provision of psychological comfort)? ____ Yes ____ No

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

_____

_____

_____

Printed Provider's Name _____

Medical Practice/Specialty _____

Business Address _____

Telephone (_____) _____ **Fax** (_____) _____

_____

Signature of Health Care Provider **Date**

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Patient Name: _____

Leave Requested By: FIRST <FirstName /> MIDDLE LAST <LastName />

Additional Information Sheet

If you have ***additional information*** to be provided, please use the below space. Identify question number with your additional answer: _____

Please initial and date any information provided on this page.

Initials of health care provider _____ **Date** _____

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