

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



<FormBarcodeValuePage2 />

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 of 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:* _____

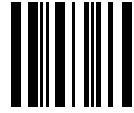
2. Approximate date symptoms/medical condition started: _____

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

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



<FormBarcodeValuePage3 />

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

