Certification of Health Care Provider for
Employee's Serious Health Condition

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PATIENT'S NAME: <FirstName /> ____________ <LastName />
FIRST MIDDLE LAST

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 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 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 seeks leave (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:*______________________________

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2. Is the medical condition pregnancy? ___Yes ___No. If yes, expected delivery date: ______________

3. Approximate date symptoms/medical condition started: ______________________________

4. Probable duration of medical condition:______________________________

5. Was the patient admitted for an inpatient stay to a hospital, hospice, or residential medical care facility? ____Yes ____No. If yes, dates of admission: ______________________________

Dates(s)/Type(s) of Treatment

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):______________________________

   b. Date(s) of anticipated treatment(s):______________________________

8. a. Indicate the estimated number of treatment(s)/visit(s), and/or estimated duration of medical treatment/visit:

   - Estimated *treatment schedule*: ____times **per** _____ week(s) ____month(s) ____year(s)
   - Estimated *recovery* for each *treatment*: ____hours or ____day(s) **per** treatment

   b. Is it *medically necessary* for the patient to attend treatments? ____Yes ____No

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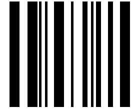
Return completed form to the patient, or mail or fax to: <CorporateBrand /> Leave Management Center, P.O. Box 100158, Columbia, SC 29202-3158; Fax: 866-249-3831 (International fax 423-294-1285); Phone: 866-779-1054



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9. Is it necessary for the patient to have *two or more* treatment and/or visits 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 (e.g., physical therapist)? ____Yes ____No

Nature and estimated duration of treatments:____

Limitations and Need for Leave Caused by Condition (Past/Present/Future)

12. Answer this section based on the patient's description of his/her job function(s) OR the job description, if attached. Job description is attached, if checked here: ☐

a. ☐ The patient is ***able*** to perform *all* functions of his/her job.

☐ The patient is ***unable*** to perform *one or more* of his/her job function(s).

Identify the job function(s) the patient is ***unable*** to perform: ________________________________

____

b. Does this condition cause a ***full/continuous*** period of inability to perform his/her job function(s)?
____Yes ____No

If ***inability to perform job function(s) is on an intermittent or reduced*** basis, see question 13.)

c. If yes, estimate the dates of inability, including any time for treatment and recovery:

From ______________________Through___________________________

13. Answer the following questions *for an* ***intermittent leave or a reduced work schedule***.

a. Is it medically necessary for the patient to be off work due to episodic flare-ups on an intermittent basis or to work less than the patient's normal work schedule? ____Yes ____No

If "Yes", please provide an estimated frequency and duration below:

b. **Episodic flare ups:**

- Estimated *episode frequency*: ____ times **per** ____week(s) ____month(s) ____year(s)
- Estimated *episode duration*: ____ hours (or) ____ day(s) **per** flare up

c. **Reduced schedule:** ____ hour(s) **per** day; ____days **per** week from: ________________________

Printed Provider's Name_________________________________**Type of Practice:**__________________

Business address ____

Telephone: (_______)____________________________ **Fax:** (_______)__________________________

_______________________________________ _____________________________

Signature of Health Care Provider **Date**

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PATIENT'S NAME: <FirstName /> ______________________ <LastName />
First Middle Last

Additional Information Sheet

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

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Please initial and date any information provided on this page.

Initials of health care provider________ **Date**__________

Leave #
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