Family Member
Serious Health Condition Certification

Family & Medical Leave Act AFSCME & PSSU

SECTION 1: TO BE COMPLETED BY EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section 1 before giving this form to your family member's health care provider. 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 (SPF Absence) 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 and SPF Absence. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA and SPF Absence request. Section 2 of this form must be completed by the treating health care provider; it is inappropriate for it to be completed by anyone other than that provider. Note: If this is a request for leave for yourself or a serious injury or illness for a covered service member, you cannot use this form. Please obtain either: *Employee Serious Health Condition Certification* OR *Serious Injury or Illness of a Servicemember Certification* from your Human Resource Office.

Employee Name	Personnel Number

University	Work Location

For Absences for Family Members, state the following:

Family Member / Patient Name	Relationship to Employee	If Son/Daughter, Date of Birth

Describe the care you will provide to your family member.

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 to the HEALTH CARE PROVIDER: The employee listed above 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 be sure to sign the form on the last page.

Supporting Medical Certification:

1. What is the approximate date the condition commenced?

2. What is the probable duration of the condition?

3. When did the incapacity commence? (Incapacity is the inability to work, attend school or perform other regular daily activities.)

4. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ☐ Yes ☐ No

   If yes, please list the most recent date of admission and discharge.

5. List date(s) you treated the patient for this condition.

6. Will the patient need to have treatment visits at least twice per year due to this condition? ☐ Yes ☐ No

7. Was medication, other than over-the-counter medication, prescribed? ☐ Yes ☐ No

8. Was the patient referred to another health care provider(s) for evaluation or treatment (example: physical therapy)? ☐ Yes ☐ No

   If yes, state the nature of such treatments and expected duration of treatment.

9. Is the medical condition pregnancy? ☐ Yes ☐ No

Employee Name ______________________________ Personnel Number ______________________

If yes, state the expected delivery date.

Medical Facts:

10. Describe other 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 Leave Needed:

11. Was or will the patient be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ☐ Yes ☐ No

If yes, estimate the beginning and ending date for the period of incapacity.
During this time, will the patient need care? ☐ Yes ☐ No

Explain the care the employee will provide for the patient and why such care is medically necessary.

12. Did or will the patient need to attend follow-up treatment or evaluation appointments? ☐ Yes ☐ No

If yes, can treatments or appointments be scheduled during non-work hours? ☐ Yes ☐ No

If yes, are the treatments/appointments medically necessary? ☐ Yes ☐ No

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

Explain the care the employee will provide for the patient, e.g., transportation, and why such care is medically necessary.

13. Did or will the patient require care by the employee on a reduced-schedule basis, including time for recovery? ☐ Yes ☐ No

If yes, estimate the hours the patient needs care on a reduced-schedule basis, if any.

Hours per day: _______ Days per week: _______
List begin and end date of such schedule:
Explain the care the employee will provide for the patient and why such care is medically necessary.

14. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities?
☐ Yes ☐ No

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 the patient may have over the next six months (example: 1 episode every 3 months last 1-2 days).

Frequency: Number of times per week or month: _____ ☐ week or ☐ month

Duration: Number of hours or days per episode: _____ ☐ hours or ☐ days

Does the patient need care during these flare-ups? ☐ Yes ☐ No

Explain the care the employee will provide for the patient 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 Person Completing the form, if not the Health Care Provider		Fax Number

Employee Name ____ Personnel Number ____________________________

Signature of Health Care Provider **(A STAMPED SIGNATURE IS NOT ACCEPTABLE.)**	Date

Return completed form to the employee or return it directly by mail or fax to:
Jessica Kornhausl ESU: 200 Prospect StreetEast Stroudsburg, PA 18301 Ph: 570-422-3147 Fax: 570-422-3450