Form 3501FR.50B, Certification of Health Care Provider for Employee's Serious Health Condition
(Family and Medical Leave Act)

Rev. May 26, 2015

Please fax the completed form to 203-436-4240

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary.

Employer name and contact: **Yale University Leave of Absence Coordinator 203-436-4240 (fax)**

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____

_____

_____

Check if job description is attached: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own 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. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient 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 upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may be sufficient to determine FMLA coverage, except in cases where more specific estimates are possible. Limit your responses to the condition for which the employee is seeking leave. Space for additional information can be found at the end of this form, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____)_____ Fax: (_____)_____

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PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ___No ___Yes

If so, dates of admission:_____

Date(s) you treated the patient for condition_____

Will the patient need to have treatment visits at least twice per year due to the condition? ___No ___ Yes

Was medication, other than over-the-counter medication, prescribed? ___No ___Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ___No ___Yes

If so, state the expected duration of treatment_____

2. Is the medical condition pregnancy? ___No ___Yes

If so, expected delivery date: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition? ___No ___Yes

If so, identify the job functions the employee is unable to perform:_____

_____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

_____

_____

_____

_____

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PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ___Yes

If so, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___No ___Yes

If so, are the treatments or the reduced number of hours of work medically necessary? ___No ___Yes

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

_____

Estimate the part-time or reduced work schedule the employee needs, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ___No ___Yes

Is it medically necessary for the employee to be absent from work during the flare-ups? ___No ___Yes

If so, explain:_____

_____

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 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or _____ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY THE QUESTION NUMBER AND YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

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Signature of Health Care Provider **Date**

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