Certification of Health Care Provider
Employee's Serious Health Condition

(Family and Medical Leave Act)

Section I - For Completion by Employee: Complete the Employee Information section, sign page 3, and give it to your health care provider to complete. Have your provider return the completed form to you. You will need to return this form to The Hartford no later than 15 days from the date you requested your leave.

Forms can be mailed to: Hartford Leave Management
P. O. Box 14869
Lexington, KY 40512-4869

OR faxed to: Toll Free Fax (833) 357-5153

This form must be returned no later than: ____________

Employee Information

Employee's Name: Last 4 digits of Social Security Number:

Leave ID: Date of Birth:

Employer's Name:

Today's Date:

Employee's Job Title: Regular Work Schedule:

Employee's Essential Job Functions:

☐ Check if Job Description Is Attached.

Section II - For Completion by the Health Care Provider: (See Part A and Part B attached)

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 not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave, please be sure to sign the form on the last page.

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 the manifestation of disease or disorder in family members of the individual, an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services and genetic information of a fetus carried by an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Provider's name:

Provider's Business Address:

Type of Practice/Medical Specialty:

Telephone Number: ( ) Fax Number: ( )

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Employee’s Name: Leave ID:

PART A - Medical Facts (For Completion by the Health Care Provider)

Approximate date condition commenced: Probable duration of condition:

1) Was the employee admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
☐ No ☐ Yes If so, dates of admission:

2) Date(s) you treated the employee in your office for condition:

3) Will the employee need to have treatment visits at least twice per year due to the condition? ☐ No ☐ Yes

4) Was medication, other than over-the-counter medication, prescribed? ☐ No ☐ Yes

5) Was the employee referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
☐ No ☐ Yes If so, state the nature of such treatments and expected duration of treatment.

6) Is the medical condition pregnancy? ☐ No ☐ Yes If so, expected delivery date:

7) Use the information provided in Section I to answer this question. If a list of the employee's essential functions or a job description is not included in section I, 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.

8) Provide the Medical Facts that support your certification. Such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment as the use of specialized equipment. ***(NOTE: 1) Do not include diagnosis information for employees/patients who work in CT, ME, or RI. 2) Do not complete this section for employees/patients who work in HI or MT if you answered YES to question 6 above).***

Employee's Name: Leave ID:

PART B: Amount Of Leave Needed: (For Completion by the Health Care Provider)

1) Will the employee be incapacitated for a single continuous period of time, including any time for treatment and recovery? ☐ No ☐ Yes

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

2) Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employees medical condition? ☐ No ☐ Yes

If so, are the treatments or the reduced number of hours of work medically necessary? ☐ No ☐ Yes

3) Estimate treatment/appointment schedule, if any, over the next 6 months including any recovery period:

Treatment/Appointment Frequency: ______ times per ______ week(s) or ______ month(s)

Treatment/Appointment Duration: ______ hours or ______ days(s) per treatment/appointment

Dates of scheduled treatment(s)/appointment(s): ______

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

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

5) Will the condition cause episodic flare-ups periodically preventing the employee from participating in normal daily activities? ☐ No ☐ Yes

6) Is it medically necessary for the employee to be absent from work during the flare-up s? ☐ No ☐ Yes
If so, explain:

7) Based upon the employee's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the employee 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 not provided above relative to the leave request.

______

Signature of Health Care Provider **Date**

______

Signature of Employee **Date**

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F .R. § 825.500. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information.

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.