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

## U.S. Department of Labor Wage and Hour Division



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

OMB Control Number: 1235-0003 Expires: 5/31/2018

#### **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 to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

and in accordance with 29 C.F.R.	§ 1635.9, if the Genet	ic Information	n Nondiscrimination A	Act applies.
Employer name and contact:				
SECTION II: For Completion INSTRUCTIONS to the EMPL member or his/her medical provio complete, and sufficient medical member with a serious health corretain the benefit of FMLA protesufficient medical certification member with a serious health corretain the benefit of FMLA protesufficient medical certification member you at least 15 calendary our name:	OYEE: Please completer. The FMLA permit certification to support dition. If requested by etions. 29 U.S.C. §§ 20 ay result in a denial of r days to return this for	ts an employed a request for your employ 613, 2614(c)(your FMLA) m to your em	er to require that you so FMLA leave to care for the formula of th	submit a timely, for a covered family equired to obtain or a complete and 325.313. Your employer
First	Middle		Last	
Name of family member for who	m you will provide care			
Relationship of family member to	) you:	First	Middle	Last
If family member is your son	or daughter, date of bi	rth:		
Describe care you will provide to	your family member a	and estimate l	eave needed to provid	e care:
Employee Signature		 Dat	e	
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### SECTION III: For Completion by the HEALTH CARE PROVIDER

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. 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 patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Page 3 provides space for additional information, 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: ()	
PART A: MEDICAL FACTS	
1. Approximate date condition commenced:	
Probable duration of condition:	
Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? NoYes. If so, dates of admission:	
Date(s) you treated the patient for condition:	
Was medication, other than over-the-counter medication, prescribed?NoYes.	
Will the patient need to have treatment visits at least twice per year due to the condition?NoYe	es
Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist NoYes. If so, state the nature of such treatments and expected duration of treatment:	)?
2. Is the medical condition pregnancy?NoYes. If so, expected delivery date:	
3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):	

for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care: 4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? No Yes. Estimate the beginning and ending dates for the period of incapacity: During this time, will the patient need care? No Yes. Explain the care needed by the patient and why such care is medically necessary: 5. Will the patient require follow-up treatments, including any time for recovery? 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: Explain the care needed by the patient, and why such care is medically necessary: 6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? No Yes. Estimate the hours the patient needs care on an intermittent basis, if any: hour(s) per day; days per week from through Explain the care needed by the patient, and why such care is medically necessary:

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need

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A]	DDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.
	Explain the care needed by the patient, and why such care is medically necessary:
	Does the patient need care during these flare-ups? No Yes.
	Duration: hours or day(s) per episode
	Frequency: times per week(s) month(s)
	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):
	activities?NoYes.

#### 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. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. 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. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**