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

**SECTION I: For Completion by 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, recertification, 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)(l), if the Americans with Disabilities Act applies.

Employer name and contact: _____

_____

**SECTION II: For Completion by EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II before giving this form to your family member or his/her 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 to care for a covered family member with a 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. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: _____

First Middle Last Employee ID #

Name of family member for whom you will provide care: _____

First Middle Last

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____

_____ _____

Employee Signature Date



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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. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

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

**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?
____No ____Yes. If so, dates of admission: _____

Date(s) you treated the patient for condition: _____

Was medication, other than over-the-counter medication, prescribed? ____No ____Yes.

Will the patient need to have treatment visits at least twice per year due to the condition? ____No ____Yes.

Was the patient referred to other health care provider(s) for evaluation or treatment (eg. physical therapist)?
____No ____Yes. If so, state the nature of such treatments and expected duration of treatment:

_____

_____

2. Is the medical condition pregnancy? ____No ____Yes. 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):

_____

_____


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

   _____

   _____

   _____



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7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ____No ____Yes.

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

Does the patient need care during these flare-ups? ____No ____Yes.

Explain the care needed by the patient, and why such care is medically necessary: _____

_____

_____

**ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.**

_____

_____

**SIGNATURE OF HEALTH CARE PROVIDER: _____**

**PRINT NAME:_____DATE: _____**

Family Medical Leave Act (FMLA) requires covered employees to provide up to twelve (12) weeks of unpaid, job protected leave during a rolling twelve (12) month period to "eligible"employees for certain family and medical reasons and up to twenty-six (26) weeks of leave in a single twelve (12) month period to "eligible" employees for a covered servicemember. Employees are eligible if they have been employed by ABX Air for at least (1) year and have worked 1,250 hours over the previous twelve-(12) months.

**REASONS FOR TAKING LEAVE:** Unpaid leave must be granted for any of the following reasons:

- The birth of a child, or placement of a child with you for adoption or foster care.
- Your own serious health condition.
- Because you are needed to care for your spouse, child, or parent due to his/her serious health condition.
- Because of a qualifying exigency arising out of the fact that your spouse, son or daughter, or parent is on active duty status in support of a contingency operation as a member of the National Guard or Reserves.
- Because you are the spouse, son or daughter, parent, or next of kin of a covered servicemember with a serious injury or illness.

At the employee's or employer's option, certain kinds of paid leave may be substituted for unpaid leave.

**ADVANCE NOTICE AND CERTIFICATIONS:** The employee may be required to provide advance leave notice and medical certification. Taking a leave may be denied if requirements are not meet.

- The employee ordinarily must provide thirty (30) days advance notice when the leave is "foreseeable".
- Medical certification is required to support a request for leave because a serious health condition is required within fifteen (15) calendar days of the Company's request.
- Certification to support a request for leave because of a qualifying military exigency is required within fifteen (15) calendar days of the Company's request.

**JOB BENEFITS AND PROTECTION:**

- For the duration of the FML, the employer must maintain the employee's health coverage under any "group health plan", but like all LOA's the employee must pay their portion of the insurance premium.
- You have a minimum 30-day grace period in which to make premiums payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse.
- Upon return from FML, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.
- The use of FML cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

**USE OF VACATION/SICK TIME:**

- Employees may elect to use earned vacation or sick leave for approved FML unless otherwise designated.
- For bonding with a child, the use of sick time is limited to two (2) weeks.
- For a qualified military exigency, paid time is limited to vacation or holiday pay.

**Additional conditions and/or limitations may also apply to FML requested by eligible employees**.

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