Certification of Health Care Provider (WH 380-F – FS)

for Employee's Family Member's Serious Health Condition
Family and Medical Leave Act

SECTION I: For Completion by the EMPLOYER

Company Name: City of Norwalk	Date:
Contact Name: John S. Schlosser, Personnel Administrator	Contact Phone: (203) 854-7723
Employee's Name:	

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her medical provider. You are required to submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due 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. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. **You have 15 calendar days to return this form to your employer.**

YOUR OWN:	First Name:	Middle Initial:	Last Name:
FAMILY MEMBER:	First Name:	Middle Initial:	Last Name:

Relationship of family member to you:

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

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

Employee Signature:	Date:

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. 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 care. Page 2 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's Name:

Provider's Business Address:

Type of Practice/Medical Specialty:

Phone #:	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 yes, dates of admission:

Date(s) you treated 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 (e.g., 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):

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 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:

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

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

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

Date:	Amt. of Time:	Date:	Amt. of Time:
Date:	Amt. of Time:	Date:	Amt. of Time:
Date:	Amt. of Time:	Date:	Amt. of Time:

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? ☐ No ☐ Yes

Explain the care needed by the patient and why such care is medically necessary:	Estimate the hours the patient needs care on an intermittent basis, if any. Hour(s) per day: Days per week: From: Through:

7. Will the condition cause flare-ups that periodically prevent 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:	**Date:**