FMLASource®

Medical Certification for FMLA - Employee

Your Healthcare Provider/ Case Worker must complete and return this form to FMLASource

Confidential fax: 877-309-0218 or Mail: FMLASource, 455 N. Cityfront Plaza Drive, Chicago, IL 60611-5322

Name: ______________________________________ FMLA Leave Request Number: ____________________

Company Name: ______________________________

Step 1: Reason for Leave

I, (Health Care Provider/ Case Worker), certify the employee's medical condition meets one or more of the following conditions (please check any that apply):

Pregnancy:

I certify that the above employee is/has been/will be:

❒ *Incapacitated** due to pregnancy
❒ Receiving prenatal care
With an Expected Delivery Date:
______/______/______

New Child:

I certify that the above employee is/has been/will be:

❒ Out of work to care for or bond with a Newborn Child, or Child Newly Placed for Adoption or Foster Care
Expected Date of Birth, Adoption, or Foster Placement:
______/______/______

Hospital Stay:

I certify that the above employee is/has been/will be:

❒ An inpatient in a hospital, hospice or residential medical care facility.
❒ Out of work to receive *treatment*** for a condition connected to a previous inpatient stay.
❒ Recovering from inpatient stay and *incapacitated**

If any of the above apply, please specify dates of admission:
______/______/______ ➔ ______/______/______

Medical Condition:

I certify that the above employee is/has been/will be:

❒ *Incapacitated** for more than three consecutive days **AND** received *treatment*** at least 2 times for this condition within 30 days of incapacitation.

❒ *Incapacitated** for more than three consecutive days AND received *treatment*** for this condition **AND** prescribed a regimen of continuing *treatment*** (i.e. therapy, Rx).

❒ *Incapacitated** by or out of work to receive *treatment*** for a chronic serious health condition which requires:
- ❒ At least 2 visits for treatment per year and
- ❒ Continues over extended period of time and
- ❒ Causes episodic or continuing incapacity.*

❒ *Incapacitated** by a permanent/long-term condition for which patient is undergoing continuing *treatment*** (i.e. Alzheimer's, severe stroke).

Please indicate the dates you have treated the employee for this condition:
______/______/______ ➔ ______/______/______

____
____
____

**Incapacity is defined as inability to work or perform regular daily activities.*
***Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition.*
Treatment does not include eye, dental, or routine physical exams.
Treatment does not include voluntary Cosmetic Procedures.

We request that you do not provide us with any genetic information when responding to this request for medical information.
Please list any facts (which can include symptoms, diagnosis, prescription medication or other treatments) relevant to the condition(s):
If the employee works in the state of California, please do not provide a diagnosis.

____
____
____

I, (Health Care Provider/Case Worker) certify that the employee's medical condition does not meet at least one of the above listed conditions:

❒ **None of the above conditions apply**

Call: 877-PFG-FMLA **Email:** FMLAcenter@FMLASource.com **Visit:** www.FMLAsource.com **FAX: 877-309-0218**

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Name: ______________________________ FMLA Leave Request Number: ________________

Step 1: Reason for Leave (continued)

Please use the employee's own description of his or her essential functions or job description to answer the following questions:

Is the employee unable to perform any of his/her job functions due to the condition:
❐ Yes ❐ No

If Yes, please identify the job functions the employee is unable to perform:

____
____
____

Is the employee's health condition permanent or life-long?
❐ Yes ❐ No

Was the employee referred to other health-care provider(s) for evaluation or treatment (i.e. physical therapist)?
❐ Yes ❐ No

If Yes, please state the nature and duration of such treatments:

____
____
____

Step 2: Frequency/Duration of Leave

Continuous:

I certify that the above employee is/has been/will be incapacitated for a single continuous period due to his/her medical condition including time for treatment and recovery:

(A) Begin date: ____/____/____ End date:____/____/____
(Estimate dates if unknown)

Reduced Schedule:

I certify that the above employee will need to work the following part-time/reduced-hours schedule due to the condition:

(A) Begin date: ____/____/____ End date:____/____/____
(Estimate dates if unknown)

(B) If the schedule is fixed, please indicate hours/days per week the employee can work:

Sun.	Mon.	Tue.	Wed.	Thu.	Fri.	Sat.

(C) If the schedule varies weekly, please indicate the number of hours per day and the number of days per week the employee is able to work:
_____ Hours/Day _____ Days/Week

Intermittent/Episodic:

I certify that it is medically necessary for the employee to miss work for episodic absences due to their condition as follows:

(A) Begin date: ____/____/____ End date:____/____/____
(Estimate dates if unknown)

(B) Number of treatments/appointments scheduled:
- Frequency = ____# per ❐week ❐month ❐ year
- Duration = ____# hour(s) or ____days(s) per treatment(s)

Please **ESTIMATE** treatment schedule (if any) including pre-scheduled appointments, the time required for each appointment (including any recovery period):

____
____

(C) Will the condition cause episodic flare-ups that will prevent the employee from attending work or performing their job duties?
❐Yes ❐No

(D) Based on the patients medical history & your knowledge of the medical condition, please indicate the frequency **AND** duration of episodes of incapacitation (e.g. 3 times per 2 months lasting 1-2 days):
- Frequency = ____# time(s) per ____week(s) or ____ month(s)
- Duration = ____# hour(s) or ____days(s) per episode(s)

Step 3: Signature

Healthcare Provider / Case Worker must sign and return form directly to FMLASource.

Signature Date Date Revised Initial
____
Print Name Phone Fax
____
Type of Practice
____
Street Address City State Zip
____

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