CITY OF MEMPHIS

Medical Certification for EMPLOYEE
FMLA - Form #1B

SECTION 1: To be completed by the EMPLOYEE:

Name of Employee (Print): _____
LAST, FIRST MI

Division: _____ Job Title: _____

Employee Contact Information: _____ _____
(phone) (email)

My regular work hours/schedule is: _____to _____ from _____a.m./p.m. to _____a.m./p.m.
(days of the week)

I ☐ authorize ☐ do not authorize (check one) the health care provider identified below to provide the information requested on this form for the purpose of determining if I qualify for an FMLA leave and for a designated City of Memphis Human Resources Professional to contact the health care provider to authenticate and/or clarify the information, if needed. I understand that if I do not agree to this authorization, my FMLA leave request could be delayed or denied.

Employee's Signature: _____Date: _____

An employee who fraudulently obtains FMLA leave will be subject to disciplinary action, up to and including termination.

SECTION 2: To be completed by the HEALTH CARE PROVIDER only:

Instructions to the Health Care Provider: Your patient has indicated a need for leave under the FMLA. Answer fully and completely ALL applicable parts. Your answer should be your best estimate based on your medical knowledge and experience. "Unknown" or "indeterminate" is not sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Failure to provide sufficient information may cause the employee's FMLA request to be delayed or denied.

Part A: Medical Facts:

Approximate date condition began: _____ Probable duration: _____

Mark below as applicable:

1. Was the patient admitted for an overnight stay in the hospital, hospice, or residential medical care facility?
   ☐Yes ☐No If yes, date(s) of admission: _____
2. Dates you have treated the patient for this condition: _____
3. Will the patient need to have treatment visits at least twice per year due to the condition? ☐Yes ☐No
4. Was medication other than over-the-counter medication prescribed? ☐Yes ☐No
5. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g. physical therapist)?
   ☐Yes ☐No If yes, state the nature of such treatments, expected duration of treatment, and the name of other medical provider: _____
   _____
6. Is the medical condition due to complications of pregnancy? ☐Yes ☐No If yes, expected delivery date: _____
   Comments: _____

PLEASE COMPLETE BOTH SIDES

Continued: Name of Employee (Print): _____
LAST, FIRST MI

Answer the questions if the essential functions of the employee's job are attached.

7. Is the employee unable to perform any of his/her essential job functions due to the condition? ☐Yes ☐No
   If yes, identify the essential job functions the employee is unable to perform: _____

8. Describe relevant facts such as symptoms, diagnosis, or any regimen of continuing treatment, related to the condition for which the employee needs leave: _____

Part B: Amount of Leave Needed:

1. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition including any time for treatment and recovery? ☐Yes ☐No If yes, estimate the beginning and ending dates for the continuous period of incapacity: _____

2. Will it be medically necessary for the employee to have follow-up treatments? ☐Yes ☐No

3. If applicable, estimate times needed for treatments, appointments, and recovery: _____

4. Is it medically necessary for the employee to work part-time or a reduced work schedule? If yes, please estimate the:
   ____Hour(s) per day off work ____Day(s) per week off work / From: (date)_____ through (date)_____

5. Will the condition cause episodic flare-ups which prevent the employee from performing his/her job functions?
   ☐Yes ☐No
   Is it medically necessary for the employee to be absent from work during the flare-ups? ☐Yes ☐No If yes, explain:

6. Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of incapacity that the patient may have (e.g. an episode every 3 months lasting 1 day):

   Frequency: _____# times per ☐ week or ☐ month For: _____# hours or _____#
   day(s) per episode From: _____(date) to _____(date)

GINA Notification to Health Care Providers: 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 employees or their family members. In order 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 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 or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Signature of Health Care Provider: _____ Date: _____

Printed name of Health Care Provider: _____

Type of Practice/Medical Specialty: _____

Contact information of Health Care Provider: _____
(Address)

_____
(Phone number) (Fax) (Email address)