Family and Medical Leave Act
CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS HEALTH CONDITION

The Genetic Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting, or requiring, genetic information of an individual or family member of the individual, except as specifically allowed by this law. 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.

Employee's name:

PART A: MEDICAL FACTS

1. a. Approximate date condition commenced:

   b. Probable duration of condition:

   c. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ☐ No ☐ Yes

   If so, date(s) of admission: date(s) of discharge:

   d. Date(s) you treated the patient for condition:

   e. Will the patient need to have treatment visits at least twice per year due to the condition? ☐ No ☐ Yes

   f. Was medication, other than over-the-counter medication, prescribed? ☐ No ☐ Yes

   g. 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. What is the patient's condition/diagnosis?

3. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, or any regimen of continuing treatment such as the use of specialized equipment):

PART B: AMOUNT OF LEAVE NEEDED

4. 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? ☐ No ☐ Yes

   If so, estimate the beginning and ending dates for the period of incapacity:

5. a. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ☐ No ☐ Yes

   If so, are the treatments or the reduced number of hours of work medically necessary? ☐ No ☐ Yes

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

   c. Estimate the part-time or reduced work schedule the employee needs, if any:

   _____ hour(s) per day; _____ days per week from _____ through _____

6. a. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☐ No ☐ Yes

   b. Is it medically necessary for the employee to be absent from work during the flare-ups? ☐ No ☐ Yes

   If so, explain:

   c. 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 _____ days(s) per episode

ADDITIONAL INFORMATION. IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____ Signature of Health Care Provider

_____ Type of Practice

_____ Printed Name

_____ Telephone Number

_____ Address

_____ Date

_____ City, State, Zip Code