Family Medical Leave Act (FMLA)
Certification for the
Care of an Immediate Family Member

Massachusetts Bay Transportation Authority
Human Resources Department, FMLA Unit
10 Park Plaza, Room 4810, Boston, MA 02116
Phone 617-222-5751 Fax 617-222-3353

INSTRUCTIONS to the EMPLOYEE:

Please complete this page before giving this form to your family member or his/her medical provider. The FMLA (29 U.S.C. §§ 2613, 2614(c)(3) permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of an immediate family member. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request (29 C.F.R. § 825.313).

Name _____ Employee # _____ Area # _____

Address _____
NUMBER STREET CITY STATE ZIP

Home Phone _____ Date of Hire _____

Job Title _____ Full Time ☐ Part Time ☐

Please circle scheduled days off: SAT SUN MON TUE WED THUR FRI or VACATION RELIEF

Please check the qualifying reason for your FMLA request:

1. **Legal Spouse Son Daughter Mother Father**

   Family Member's Printed Name: _____

   If for a son or daughter, date of birth: _____

2. ***Parental Leave/Childbirth: Estimated Date of Delivery:_____**

3. ***Adoption/Foster Care – Estimated Date of Event: _____**

   *****If I am applying for Paternity or Adoption/Foster Care, I also am applying for any benefits I may be entitled to under the Massachusetts Maternity Leave (MML). If eligible for leave under FMLA, and/or the MML, I understand that the Authority shall apply any leave entitlement concurrently, unless otherwise designated by the Authority.

Employee's Signature:_____ Date: _____

Revised 08/01/10

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 your 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 your patient needs the employee to care for him/her. Page 3 provides space for additional information, should you need it. **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: _____

   Mark below as applicable:
   Was your patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

   ___No ___Yes If yes, please provide dates of hospital stay: _____

   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 and/or evaluation 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 yes, state the nature of such treatments and expected duration of treatment:

   _____

   _____

2. Is the medical condition pregnancy? ___No ___Yes
   If yes, please provide the expected delivery date: _____

3. Describe other relevant medical facts, if any, related to the condition for which your 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 your patient be incapacitated for a single continuous period of time including any time for treatment and recovery from said treatment? ___No ___Yes

   Estimate the beginning and ending dates for the period of incapacity: _____

   During this time, will the patient need care from the employee? __ No __ Yes

   If yes, explain the assistance needed, and why such care is medically necessary:

_____

_____

_____

_____

_____

5. Will your patient require follow-up treatments, including any time for recovery from said treatments? ___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 assistance needed by your patient, and why such care is medically necessary:

_____

6. Will the patient require care on an intermittent or reduced schedule basis? __ 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 intermittent care needed, and why such care is medically necessary:

_____

_____

_____

_____

_____

_____

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

Based upon your patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that your 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 your patient need care by the employee during these flare-ups? ____ No ____ Yes.

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

_____

_____

_____

_____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

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_____ _____

Signature of Health Care Provider **Date**