Date Issued: _____

CITY OF ST. LOUIS
CERTIFICATION OF HEALTH CARE PROVIDER FOR FAMILY MEMBER'S SERIOUS HEALTH CONDITION

SECTION 1: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. **Please complete Section I before giving to Employee.**

Employer name and contact: _____
_____

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. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. **Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. This form must be returned within 15 calendar days.**

Your name: _____
First Middle Last

Name of family member for whom you will provide care:
_____
First Middle Last

Relationship of family member to you: _____. If family member is your son/daughter, give date of birth: _____.

Describe care you will provide to your family member and estimate 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 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 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 leave. Page 4 provides space for additional information, should you need it. **Please be sure to sign the form on the last page**.

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 so, dates of admission:
   _____

   Date(s) you treated the patient for the 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, including any time for treatment and recovery? No ____ Yes ____.

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

   During this time, will the patient need care? No ____ Yes ____.

   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 ____.

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

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? 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 care needed by the patient, and why such care in medically necessary:
   _____
   _____
   _____
   _____

7. Will the condition cause episodic flare-ups periodically preventing 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 the flare-ups and the duration of related incapacity 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

Printed Name of Health Care Provider: _____

Type of Practice: _____

Phone Number: _____ Fax Number: _____