Certification of Health Care Provider
(Family and Medical Leave Act)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

U.S. Wage and Hour Division

DRAFT FOR COMMENT—NOT APPROVED FOR USE

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SECTION I: 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 leave due to a serious health condition to submit a medical certification issued by the health care provider of the eligible employee or of the ill family member. Please complete Section I before giving this form to your employee. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.306-.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees or employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies. Employers must retain a copy of this disclosure in their records for three years, in accordance with 29 U.S.C. § 2616; 29 C.F.R. § 825.500.

Employer name and contact:

Employee's job title: _____ Regular work schedule: _____

Essential job functions (if for employee's own serious health condition): _____

_____

Check if job description is attached: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your 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 due to your own serious health condition or that of a qualified member of your family. While you are not required to provide this information, failure to do so may result in a denial of your request for FMLA leave. Your employer must give you at least 15 calendar days to return this form to your employer.

Your Name: _____
First Middle Last

If you are seeking leave to care for a family member, name of family member:

Family Member's Name: _____
First Middle Last

Relationship of family member to you: _____

Describe care you will provide to your family member and estimate leave needed to provide care: _____

_____

If family member is your son or daughter, date of birth: _____

CONTINUED ON NEXT PAGE

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed on Page 1 has requested leave under the FMLA. Answer, fully and completely, all applicable parts. 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 employee is seeking leave. Page 4 provides space for additional information, should you need it.

Provider's Name and Business Address:_____

Type of practice: _____ Medical Specialty: _____

Telephone: (_____) _____ Fax:(_____) _____

_____ _____

Signature of Health Care Provider Date

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, dates of admission: _____

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

(e) Was medication, other than over-the-counter medication, prescribed? ___No ___Yes.

(f) 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.

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

_____

_____

_____

_____

_____

CONTINUED ON NEXT PAGE

PART B: AMOUNT OF LEAVE NEEDED

4. Will the employee need to be absent from work for a single continuous period of time due to his/her own medical condition or the need to care for the family member, including any time for treatment and recovery? ___No ___Yes.

   If so, estimate the beginning and ending dates for the period of absence: _____.

5. Will the employee need to be absent from work periodically to attend his/her own or the family member's follow-up treatment appointments or because the employee only will be able to work part-time or on a reduced schedule because of the employee's own condition or need to care for the family member? ___No ___Yes.

   If so, are the treatments or the reduced number of hours of work medically necessary? ___No ___Yes.

   Estimate treatment schedule, including the dates of any scheduled appointments: _____

   _____

   How long will the employee need to be absent for each appointment, including any necessary recovery period: _____ hour(s) ____ day(s)

   Estimate the part-time or reduced work schedule the employee needs, if any: _____ hour(s) per day; _____ days per week from _____ through _____

6. Will the condition cause episodic flare-ups periodically preventing the employee from performing the job duties or the family member from participating in normal daily activities? ____No ____Yes.

   Is it medically necessary for the employee to be absent from work during the flare-ups?

   ____ No ____ Yes. If so, explain _____

   _____

   _____

   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 (i.e., 1 episode every 3 months lasting 1-2 days):

   Frequency: _____ times per _____ week(s) _____ month(s)

   Duration: _____ hours ___ day(s) per episode

PART C: ANSWER ONLY IF PATIENT IS THE EMPLOYEE

7(a) Based upon the brief description of the essential functions in Section I, or job description if attached, indicate whether the employee is unable to perform any of the functions of his/her job during the leave period stated in Part B: ____ No ____ Yes.

7(b) If so, identify the essential functions the employee is unable to perform: _____

_____

CONTINUED ON NEXT PAGE

PART D: ANSWER ONLY IF PATIENT IS THE EMPLOYEE'S FAMILY MEMBER

8(a) If the patient is a family member, indicate whether the employee is needed to participate in the on-going treatment, including the provision of physical or psychological care or assistance with basic personal safety or transportation needs, of the family member? ____No ____Yes

(b) Describe the patient's need for care: _____

_____

_____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

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PUBLIC BURDEN STATEMENT

Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE PATIENT.**