Certification of Health Care Provider for Employee's Serious Health Condition under the Family and Medical Leave Act

U.S. Department of Labor Wage and Hour Division



DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.

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The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee at least 15 calendar days to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Additionally, you may not request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees 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, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

(1) Employee name:				
	First	Middle	Last	
(2) Employer name:			Date:	(mm/dd/yyyy)
			(List date certification	requested)
(3) The medical certification	must be returned by			(mm/dd/yyyy)
(Must allow at least 15 cale	endar days from the date requeste	ed, unless it is not feasible despite the	employee's diligent, good faith e	fforts.)
(4) Employee's job title:			Job description i	s / is not attached.
Employee's regular work	schedule:			
Statement of the employe	ee's essential job functions:			
•	the employee's position are dete ave or the leave started, whichever	rmined with reference to the position the ris earlier.)	he employee held at the time the	employee notified the

SECTION II - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient has requested leave under the FMLA. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of the employee. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves **inpatient care** or **continuing treatment by a health care provider**. For more information about the definitions of a serious health condition under the FMLA, see the chart on page 4.

You also may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

Employee Name:		
Health Care Provider's name: (Print)		
Health Care Provider's business address	s:	
Type of practice / Medical specialty:		
Telephone:	Fax:	E-mail:
PART A: Medical Information		
based upon your medical knowledge, einformation about the amount of leave regular daily activities due to the condition tests, as defined in 29 C.F.R. § 1635.3(the employee's family members, 29 C.F.	experience, and exame needed. Note: For Fon, treatment of the confly, genetic services, a R. § 1635.3(b).	e employee is seeking FMLA leave. Your answers should be your best estimate mination of the patient. After completing Part A, complete Part B to provide FMLA purposes, "incapacity" means the inability to work, attend school, or performantion, or recovery from the condition. Do not provide information about genetics defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the condition of the condition of disease or disorder in the condition of the condition of disease or disorder in the condition of the condition of the condition of disease or disorder in the condition of the condition of the condition of disease or disorder in the condition of the patients of the condition of the condit
(2) Provide your best estimate of how lo	ng the condition laste	ed or will last:
Inpatient Care: The patient (hospice, or residential medical care incapacity plus Treatment: (e.g. Due to the condition, the patient consecutive, full calendar days f	has been / is exare facility on the folloon. outpatient surgery, so (has been / rom:	For all box(es) checked, the amount of leave needed must be provided in Part B. spected to be) admitted for an overnight stay in a hospital, pwing date(s): strep throat) is expected to be) incapacitated for more than three
· · · · · · · · · · · · · · · · · · ·		n a course of continuing treatment under the supervision of a per than over-the-counter) or therapy requiring special equipment).
Pregnancy: The condition is pre	•	
Chronic Conditions: (e.g. asthm treatment visits at least twice per		nes) Due to the condition, it is medically necessary for the patient to have
		er's, terminal stages of cancer) Due to the condition, incapacity is permanent of a health care provider (even if active treatment is not being provided).
Conditions requiring Multiple 1 necessary for the patient to recei		emotherapy treatments, restorative surgery) Due to the condition, it is medically s.
None of the above: If none of the needed. Go to page 4 to sign and		were checked, (i.e., inpatient care, pregnancy) no additional information is

Employee Name:	
(4) If needed, briefly describe other appropriate medical facts related to t of nebulizer, dialysis)	the condition(s) for which the employee seeks FMLA leave. (e.g., use
PART B: Amount of Leave Needed	
For the medical condition(s) checked in Part A, complete all that apply. condition, treatment, etc. Your answer should be your best estimate be patient. Be as specific as you can; terms such as "lifetime," "unknown," of	ased upon your medical knowledge, experience, and examination of the
(5) Due to the condition, the patient (had / will have) planned (e.g.psychotherapy, prenatal appointments) on the following date(s):	
(6) Due to the condition, the patient (was / will be) referred to	other health care provider(s) for evaluation or treatment(s).
State the nature of such treatments: (e.g. cardiologist, physical therapy)	
Provide your best estimate of the beginning date	(mm/dd/yyyy) and end date (mm/dd/yyyy).
for the treatment(s). Provide your best estimate of the duration of the treatment(s), including	any period(s) of recovery (e.g. 3 days/week)
(7) Due to the condition, it is medically necessary for the employee to wo	
Provide your best estimate of the reduced schedule the employee is ab to (mm/dd/yyyy) the employee is able to work: (e	
(8) Due to the condition, the patient (was / will be) incapacita	ted for a continuous period of time, including any time
for treatment(s) and/or recovery.	
Provide your best estimate of the beginning date	(mm/dd/yyyy) and end date (mm/dd/yyyy).
for the period of incapacity.	
	sessary for the employee to be absent from work on an
intermittent basis (periodically), including for any episodes of incapacity i (frequency) and how long (duration) the episodes of incapacity will likely	· · ·
Over the next 6 months, episodes of incapacity are estimated to occur	times per
(day week month) and are likely to last approximately	(hours days) per episode.

PART C: Essential Job Functions					
If provided, the information in Section I question #4 may be used to answer this question. If the employer fails to provide a statement of the employee's essential functions or a job description, answer these questions based upon the employee's own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be not able to perform the essential job functions of the position during the absence for treatment(s).					
10) Due to the condition, the employee (was not able / is not able / will not be able) to perform one or more of the					
essential job function(s). Identify at least one essential job function the employee is not able to perform:					
	_				
Signature of Health Care Provider	Date: (mm/dd/yyyy)				
Definitions of a Serious Health Condition (See 29 C.F.R. §§ 825.113115)					
Inpatient Care					
 An overnight stay in a hospital, hospice, or residential medical care facility. Inpatient care includes any period of incapacity or any subsequent treatment in cor 	nnection with the overnight stay.				
Continuing Treatment by a Health Care Provider (any one or more of the following	a)				
Incapacity Plus Treatment : A period of incapacity of more than three consecutive, full treatment or period of incapacity relating to the same condition, that also involves either					
o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or,					
o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.					
Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.					
Chronic Conditions : Any period of incapacity due to or treatment for a chronic serious asthma, migraine headaches. A chronic serious health condition is one which requires supervised by the provider) at least twice a year and recurs over an extended period of episodic rather than a continuing period of incapacity.	visits to a health care provider (or nurse				
Permanent or Long-term Conditions : A period of incapacity which is permanent or lo treatment may not be effective, but which requires the continuing supervision of a healt disease or the terminal stages of cancer.					
Conditions Requiring Multiple Treatments: Restorative surgery after an accident or a likely result in a period of incapacity of more than three consecutive, full calendar days	• •				

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. 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 15 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 Avenue, N.W., Washington, D.C. 20210.

Employee Name: