Certification of Health Care Provider for Family Member'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 leave to care for a family member with a serious health condition to submit a medical certification issued by the family member'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

(1) Employee name

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 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, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

	First	Middle	Last	
(2) Employer name:			Date:	(mm/dd/yyyy)
			(List date certification red	
(3) The medical certification r	nust be returned by			(mm/dd/yyyy)
(Must allow at least 15 caler	ndar days from the date requested, ι	unless it is not feasible despite the	e employee's diligent, good faith effort	s.)
SECTION II - EMPLOYEE				
allows an employer to require the serious health condition the FMLA protections. 29 U. employer within the time fr	e that you submit a timely, comp of your family member. If reque S.C. §§ 2613, 2614(c)(3). You a	plete, and sufficient medical co sted by your employer, your are responsible for making be at least 15 calendar days	rour family member's health care ertification to support a request for response is required to obtain or sure the medical certification is 29 C.F.R. §§ 825.305-825.306. uest. 29 C.F.R. § 825.313.	FMLA leave due to retain the benefit of sprovided to your
(1) Name of the family memb	er for whom you will provide car	e:		
(2) Select the relationship of	the family member to you. The fa	amily member is your:		
Spouse	Parent	Child, under a	ge 18	
Child, age 18 or	older and incapable of self-care	because of a mental or physic	cal disability	

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including in a common law marriage or same-sex marriage. The terms "child" and "parent" include in loco parentis relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for an individual who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a child for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.

Employee Name:						
(3) Briefly describe the care you will provide to your family member: (Check all that apply) Assistance with basic medical, hygienic, nutritional, or safety needs Physical Care Psychological Comfort Other: (4) Give your best estimate of the amount of leave needed to provide the care described:						
(5) If a reduced work schedule is necessaryou are able to work. From(hours per day)	(mm/dd/yyyy) to _		ed schedule ble to work			
Employee Signature		Date	(mm/dd/yyyy			
SECTION III - HEALTH CARE PROVI	DER					
Please provide your contact information, of has requested leave under the FMLA to complete, and sufficient medical certification. For FMLA purposes, a "serious health concare or continuing treatment by a health consee the chart at the end of the form. You also may, but are not required to, put treatment such as the use of specialized information about the patient's serious health.	care for your patient. The FM on to support a request for FN ndition" means an illness, injuare provider. For more informative other appropriate medical equipment. Please note that	ILA allows an employer to require that the MLA leave to care for a family member woury, impairment, or physical or mental control about the definitions of a serious heat call facts including symptoms, diagnosis some state or local laws may not allow	the employee submit a timely with a serious health condition ondition that involves inpatien alth condition under the FMLA, or any regimen of continuing disclosure of private medical			
Health Care Provider's name: (Print)						
Health Care Provider's business address:						
Type of practice / Medical specialty:						
Telephone:	Fax:	E-mail:				
PART A: Medical Information Limit your response to the medical condition based upon your medical knowledge, explinformation about the amount of leave regular daily activities due to the condition tests, as defined in 29 C.F.R. § 1635.3(f), the employee's family members, 29 C.F.R. (1) Patient's Name:	perience, and examination of needed. Note: For FMLA purpo , treatment of the condition, or genetic services, as defined i	the patient. After completing Part A, oses, "incapacity" means the inability to ver recovery from the condition. Do not proin 29 C.F.R. § 1635.3(e), or the manifest	complete Part B to provide work, attend school, or perform ovide information about genetic			
(2) State the approximate date the condition(3) Provide your best estimate of how long						
(4) For FMLA to apply, care of the patient r assistance with basic medical, hygienic, nu	must be medically necessary. E	Briefly describe the type of care needed b	by the patient (e.g.,			

Employee Name:					
5) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Pa	rt B.				
☐ Inpatient Care: The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s):					
Incapacity plus Treatment: (e.g. outpatient surgery, strep throat)					
Due to the condition, the patient (has been / is expected to be) incapacitated for more than three					
consecutive, full calendar days from: (mm/dd/yyyy) to (mm/dd/yyyy).					
The patient (was / will be) seen on the following date(s):					
The condition (has / has not) also resulted in a course of continuing treatment under the supervision of a health care provider (e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment)					
Pregnancy: The condition is pregnancy. List the expected delivery date: (mm/dd/yyyy).					
Chronic Conditions: (e.g. asthma, migraine headaches) Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.					
Permanent or Long Term Conditions: (e.g. Alzheimer's, terminal stages of cancer) Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).					
Conditions requiring Multiple Treatments: (e.g. chemotherapy treatments, restorative surgery) Due to the condition, it is medical necessary for the patient to receive multiple treatments.	lly				
None of the above: If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.					
6) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. (e.g., ι of nebulizer, dialysis)	ıse				
PART B: Amount of Leave Needed					
For the medical condition(s) checked in Part A, complete all that apply. Several questions seek a response as to the frequency or duratic condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine if the benefit protections of the FMLA apply.	of the				
7) Due to the condition, the patient (had / will have) planned medical treatment(s) (scheduled medical visits) (e.g.					
osychotherapy, prenatal appointments) on the following date(s):					
8) 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). or 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)					

Employee Name:		
(9) Due to the condition, the patient (was / will be) incapacitated fo	or a continuous period of time, incl	luding any time
for treatment(s) and/or recovery.		
Provide your best estimate of the beginning date (mm/dd/yyyy) and end date (m		
(10) Due to the condition, it (was / is / will be) medically necess	ary for the employee to be absent fr	om work to
provide care for the patient on an intermittent basis (periodically), including for best estimate of how often (frequency) and how long (duration) the episodes		isodic flare-ups. Provide your
Over the next 6 months, episodes of incapacity are estimated to occur		times per
(day week month) and are likely to last approximately	(h	ours
Signature of Health Care Provider	Date:	(mm/dd/yyyy)
Definitions of a Serious Health Condition (See 29 C.F.R. §§ 825.113	3115)	
Inpatient Care		
 An overnight stay in a hospital, hospice, or residential medical car Inpatient care includes any period of incapacity or any subsequen 	•	e overnight stay.
Continuing Treatment by a Health Care Provider (any one or more	of the following)	
Incapacity Plus Treatment: A period of incapacity of more than three treatment or period of incapacity relating to the same condition, that also of Two or more in-person visits to a health care provider for treat extenuating circumstances exist. The first visit must be within of At least one in-person visit to a health care provider for treating results in a regimen of continuing treatment under the superprovider might prescribe a course of prescription medication.	so involves either: atment within 30 days of the first n seven days of the first day of ir ment within seven days of the firs vision of the health care provider	day of incapacity unless ncapacity; or, st day of incapacity, which r. For example, the health
Pregnancy: Any period of incapacity due to pregnancy or for prenatal	care.	
Chronic Conditions : Any period of incapacity due to or treatment for asthma, migraine headaches. A chronic serious health condition is one supervised by the provider) at least twice a year and recurs over an exepisodic rather than a continuing period of incapacity.	e which requires visits to a health	care provider (or nurse
Permanent or Long-term Conditions : A period of incapacity which is treatment may not be effective, but which requires the continuing super disease or the terminal stages of cancer.		
Conditions Requiring Multiple Treatments: Restorative surgery after	er an accident or other injury: or	a condition that would

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.

likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.