Family and Medical Leave Act
CERTIFICATION OF HEALTH CARE PROVIDER FOR FAMILY MEMBER'S SERIOUS HEALTH CONDITION

SECTION I: For Completion by the EMPLOYEE

Please complete this section before giving this form to your family member or his/her medical provider.

Employee's name:
Name of family member for whom employee will provide care:
Relationship of family member to employee: If family member is employee's son or daughter, date of birth: Is son/daughter over the age of 18? ☐ No ☐ Yes (If yes, health care provider also completes Part C: Medical Facts – Disability – For Son or Daughter Over the Age of 18 in addition to Parts A and B.)
Describe care that will be provided to family member by employee and estimate leave needed to provide care:
_____ _____ Employee Signature Date

SECTION II: For Completion by the HEALTH CARE PROVIDER

The Genetic Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting, or requiring, genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

PART A: MEDICAL FACTS – FMLA CONDITION

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, date(s) of admission: date(s) of discharge:

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

e. Will the patient need to have treatment visits at least twice per year due to the condition? ☐ No ☐ Yes

f. Was medication, other than over-the-counter medication, prescribed? ☐ No ☐ Yes

g. 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. What is the patient's condition/diagnosis?

3. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, 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 or care by the employee seeking leave may include assistance with basic medical, hygiene, nutritional, safety or transportation needs, or the provision of physical or psychological care.

4. a. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ☐ No ☐ Yes

If so, estimate the beginning and ending dates for the period of incapacity:

b. 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. a. 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:

b. Explain the care needed by the patient, and why such care is medically necessary:

6. a. 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 _____

b. Explain the care needed by the patient, and why such care is medically necessary:

7. a. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ☐ No ☐ Yes

b. 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 (e.g. 1 episode every 3 months lasting 1-2 days):

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

Duration: _____ hours or _____ days(s) per episode

c. 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:

PART C: MEDICAL FACTS – DISABILITY – FOR SON OR DAUGHTER OVER THE AGE OF 18
To be completed ONLY for employees requesting Family Medical Leave to care for a child over the age of 18.

1. Please indicate which of the following "activities of daily living" or "instrumental activities of daily living" that the adult son/daughter requires active assistance or supervision to perform:

☐ Caring for own grooming and hygiene	☐ Cooking	☐ Maintaining a residence
☐ Bathing	☐ Cleaning	☐ Using telephones/directories
☐ Dressing	☐ Eating	☐ Using a post office
☐ Paying Bills	☐ Shopping	☐ Taking Public Transportation
☐ Other		

2. To address the following, please note that "major life activities" include, but are not limited to, functions such as "caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.* The following questions address if the physical or mental disability "substantially limits" one or more of the major life activities of the adult son or daughter:

a. Does the adult son/daughter have a medically recognized physical or mental disability, defined as "a physical or mental impairment that substantially limits one or more of the major life activities"? ☐ No ☐ Yes

b. Is the adult son or daughter unable to perform a major life activity that the average person in the general population can perform? ☐ No ☐ Yes

c. Is he/she significantly restricted as to the condition, manner, or duration under which he/she can perform a particular major life activity as compared to the condition, manner, or duration under which the average person in the general population can perform that same major life activity? ☐ No ☐ Yes

3. What is the nature and severity of the impairment?

4.	What is the duration or expected duration of the impairment?
5.	What is the permanent or long-term impact, or the expected permanent or long-term impact of or resulting from the impairment?

ADDITIONAL INFORMATION. IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Signature of Health Care Provider	Type of Practice
Printed Name	Telephone Number
Address	Date
City, State, Zip Code	

*The term "substantially limits working" means significantly restricted in the ability to perform either a class of jobs or a broad range of jobs in various classes as compared to the average person having comparable training, skills and abilities. The inability to perform a single, particular job does not constitute a substantial limitation in the major life activity of working. In addition to these factors, the following may be considered in determining whether an individual is substantially limited in the major life activity of "working": The geographical area to which the individual has reasonable access; the job from which the individual has been disqualified because of an impairment, and the number and types of jobs utilizing similar training, knowledge, skills or abilities, within that geographical area, from which the individual is also disqualified because of the impairment (class of jobs); and/or; the job from which the individual has been disqualified because of an impairment, and the number and types of other jobs not utilizing similar training, knowledge, skills or abilities, within that geographical area, from which he individual is also disqualified because of the impairment (broad range of jobs in various classes).