# Certification of Health Care Provider for Employee's Serious Health Condition (Family and Medical Leave Act)

Shelby County Board of Education

## SECTION I: For Completion by the EMPLOYEE

**INSTRUCTIONS to the EMPLOYEE:** 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. Please complete Section I before giving this form to your health care provider.

Employer name and contact number: _____

Employee's job title: _____

## 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. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a delay or denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: _____
First Middle Last

**An employee who fraudulently obtains FMLA leave will be subject to disciplinary action, up to and including termination.**

## SECTION III: For Completion by the HEALTH CARE PROVIDER

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** Your patient 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. Please be sure to sign the form on the last page 3.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

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


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**Continued: Name of Employee (Print): _____**
First Middle Last

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   **Mark below as applicable:**
   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 condition:

   _____

   Will the patient need to have treatment visits at least twice per year due to the condition? ___No ___ Yes

   Was medication, other than over-the-counter medication, prescribed? ___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. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   Is the employee unable to perform any of his/her job functions due to the condition: _____ No ____ Yes

   If so, identify the job functions the employee is unable to perform:

   _____

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

   _____

   _____

   _____

   _____

   _____

CONTINUED ON NEXT PAGE

**Continued: Name of Employee (Print): _____**

First Middle Last

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ___Yes

**The estimated return to work date must be an actual date. (If applicable, the estimated return to work date can be extended with a new completed medical statement).We are unable to use pending, undetermined, unknown, until further notice, or periods indicating just the number of weeks or months:**

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

**(Required) Beginning Date** ____ /_____/_____ **(Required) Return to Work Date**_____/_____/_____
(First Date of Consecutive Absence) mm dd yyyy (Estimated Date) mm dd yyyy

6. Will the employee need to attend follow-up treatment appointments or **(intermittently)** work part-time or on a reduced schedule because of the employee's medical condition? ____No ___Yes

If so, are the treatments or the reduced number of hours of work medically necessary?
___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:

_____

Estimate the part-time or reduced work schedule the employee needs, if any:

_____hour(s) per day; _____ days per week from _____through _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____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 (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

**Gina Notification to Health Care Providers: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or family members. In order to comply with this law, we are asking that you do 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 than individual or an individual's family sought or received genetic services, and genetic information of a fetus carried by an individual or individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.**

_____

**Signature of Health Care Provider** **Date**

_____