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 requeste	
(3) The medical certification	tion must be returned by			_ (mm/dd/yyyy)
(Must allow at least 15	calendar days from the date requested,	unless it is not feasible despite the	he employee's diligent, good faith efforts.)	
SECTION II - EMPLO	YEE			
allows an employer to re the serious health condi the FMLA protections. 2 employer within the tir	quire that you submit a timely, complition of your family member. If reques 9 U.S.C. §§ 2613, 2614(c)(3). You	plete, and sufficient medical of ested by your employer, your are responsible for making be at least 15 calendar day	your family member's health care provious certification to support a request for FML response is required to obtain or retain g sure the medical certification is prove. 29 C.F.R. §§ 825.305-825.306. Failuquest. 29 C.F.R. § 825.313.	A leave due to the benefit of ovided to your
(1) Name of the family m	ember for whom you will provide car	re:		
(2) Select the relationshi	p of the family member to you. The f	amily member is your:		
Spouse	Parent	Child, under	age 18	
Child, age 1	8 or older and incapable of self-care	because of a mental or physi	ical 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 provid	le to your family member	: (Check all that apply)	
Assistance with basic medical	al, hygienic, nutritional, o	r safety needs Transportation	1
Physical Care Ps	sychological Comfort	Other:	
(4) Give your best estimate of the amount	t of leave needed to prov	ide the care described:	
(5) If a reduced work schedule is necess you are able to work. From (hours per day)	(mm/dd/yyyy	escribed, give your best estimate of to (mm/dd/yyyy),	
Employee Signature		Date	e (mm/dd/yyyy
SECTION III - HEALTH CARE PROV	IDER		
Please provide your contact information, has requested leave under the FMLA to complete, and sufficient medical certificat For FMLA purposes, a "serious health cocare or continuing treatment by a health cosee the chart at the end of the form. You also may, but are not required to, pure treatment such as the use of specialized information about the patient's serious health.	care for your patient. To ion to support a request ondition" means an illnessare provider. For more in provide other appropriate the equipment. Please note	he FMLA allows an employer to req for FMLA leave to care for a family ss, injury, impairment, or physical or information about the definitions of a s e medical facts including symptoms, e that some state or local laws may	uire that the employee submit a timely member with a serious health condition mental condition that involves inpatien erious health condition under the FMLA diagnosis, or any regimen of continuing not allow disclosure of private medica
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 cond based upon your medical knowledge, exinformation 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.	perience, and examinat needed. Note: For FMLA n, treatment of the condit n, genetic services, as de	ion of the patient. After completing A purposes, "incapacity" means the intion, or recovery from the condition. I	g Part A, complete Part B to provide ability to work, attend school, or perform no not provide information about genetic
(1) Patient's Name:			
(2) State the approximate date the condition	on started or will start: _		(mm/dd/yyyy)
(3) Provide your best estimate of how long	g the condition lasted or	will last:	
(4) For FMLA to apply, care of the patient assistance with basic medical, hygienic, n			

Employee Name:		
5) Check the box(es) for the questions below, as applicable. For all box(e	es) checked, the amount of leave needed	must be provided in Part B.
☐ Inpatient Care: The patient (☐ has been / ☐ is expected to b 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 expecte	d to be) incapacitated for more than three	e
consecutive, full calendar days from: (mm/do	d/yyyy) to(mm/dd/yyy	y).
The patient (was / will be) seen on the following date(s):	
The condition (has / has not) also resulted in a course health care provider (e.g. prescription medication (other than over		
Pregnancy: The condition is pregnancy. List the expected deliv	very date: (mm/do	d/yyyy).
Chronic Conditions: (e.g. asthma, migraine headaches) Due to t treatment visits at least twice per year.	the condition, it is medically necessary for	the patient to have
Permanent or Long Term Conditions: (e.g. Alzheimer's, termina or long term and requires the continuing supervision of a health care.		
Conditions requiring Multiple Treatments: (e.g. chemotherapy necessary for the patient to receive multiple treatments.	treatments, restorative surgery) Due to th	e condition, it is medically
None of the above: If none of the above condition(s) were checked needed. Go to page 4 to sign and date the form.	ed, (i.e., inpatient care, pregnancy) no add	ditional information is
6) If needed, briefly describe other appropriate medical facts related to thof nebulizer, dialysis)	ne condition(s) for which the employee see	eks FMLA leave. (e.g., use
PART B: Amount of Leave Needed		
For the medical condition(s) checked in Part A, complete all that apply. Scondition, treatment, etc. Your answer should be your best estimate bas patient. Be as specific as you can; terms such as "lifetime," "unknown," corotections of the FMLA apply.	sed upon your medical knowledge, exper	rience, and examination of the
7) Due to the condition, the patient (had / will have) planned in paychotherapy, prenatal appointments) on the following date(s):	medical treatment(s) (scheduled medica	,
8) Due to the condition, the patient (was / will be) referred to	other health care provider(s) for evalua	ition or treatment(s).
State the nature of such treatments: (e.g. cardiologist, physical therapy)		
Provide your best estimate of the beginning date (or the treatment(s).	mm/dd/yyyy) and end date	(mm/dd/yyyy).
Provide your best estimate of the duration of the treatment(s), including a	any period(s) of recovery (e.g. 3 days/wee	ek)

Employee Name:			
(9) Due to the condition, the patient (was / will be) incapac	citated for a continuous perio	d 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/y	ууу).
for the period of incapacity.		- h h 	
(10) Due to the condition, it (was / is / will be) medicall			Duna dala
provide care for the patient on an intermittent basis (periodically), incest estimate of how often (frequency) and how long (duration) the extension of the patient of th			Provide your
Over the next 6 months, episodes of incapacity are estimated to occu	r		times per
(day week month) and are likely to last approximate	ely	(hours days)	per episode.
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 med Inpatient care includes any period of incapacity or any sub 	-	ction with the overnight stay	
Continuing Treatment by a Health Care Provider (any one of	or more of the following)		
Incapacity Plus Treatment: A period of incapacity of more that treatment or period of incapacity relating to the same condition o Two or more in-person visits to a health care provide extenuating circumstances exist. The first visit must	n, that also involves either: er for treatment within 30 day be within seven days of the	ys of the first day of incapac first day of incapacity; or,	ity unless
 At least one in-person visit to a health care provider results in a regimen of continuing treatment under the provider might prescribe a course of prescription me 	ne supervision of the health	care provider. For example	
Pregnancy : Any period of incapacity due to pregnancy or for p	renatal care.		
Chronic Conditions : Any period of incapacity due to or treatments, migraine headaches. A chronic serious health conditions supervised by the provider) at least twice a year and recurs over episodic rather than a continuing period of incapacity.	on is one which requires visit	ts to a health care provider (or nurse
Permanent or Long-term Conditions : A period of incapacity treatment may not be effective, but which requires the continu disease or the terminal stages of cancer.			
Conditions Requiring Multiple Treatments: Restorative surg	gery after an accident or oth	er injury; or, a condition that	t 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.