Certification of Healthcare Provider for Family Member's Serious Health Condition (Family and Medical Leave Act)

Formula Corporation
FMLA Administrator
2919 Eagandale Blvd, Suite 120
Eagan, MN 55121
www.formulabenefits.com
651.379.9248; 1.888.686.0513 x106

Section I: For Completion by the Employee

Employer Name: ______________________________

Employer Contact: ______________________________

Employer Address: ______________________________

Employer Telephone: ____________________ Fax: ____________________

INSTRUCTIONS to the EMPLOYEE: **Please complete Section I before giving this form to your family member or his/her 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 to care for a covered family member with a 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 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 to your

Your Name: ______________________________
First Middle Last

Address: ______________________________

Home Telephone: ____________________ Cell: ____________________

Name of family member for whom you will provide care: ______________________________
First Middle Last

Relationship of family member to you: ______________________________

If family member is your son or daughter, date of birth: ______________________________

Describe care you will provide to your family member/Estimate leave time/Schedule needed to provide care:

____

____

____
Employee Signature Date

Continued On Next Page

Section II: For Completion by the Healthcare 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.

Provider's Name: ______________________________

Provider's Business address: ______________________________

Type of practice/Medical specialty: ______________________________

Telephone:(   ) ______________________________ Fax:(   ) ______________________________

PART A: Medical Facts

1. Approximate date condition began: ___/___/______

Probable duration of condition: ______________________________

____

Was the patient admitted for an overnight stay in a hospital or residential medical care facility? ☐ Yes ☐ No

If yes, 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? ☐ Yes ☐ No

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

Was the patient referred to other healthcare provider(s) for evaluation or treatment(e.g.,physical therapist)? ☐Yes ☐No

If yes, state the nature of such treatments and expected duration of treatment: ______________________________

____

____

____

2. Is the medical condition pregnancy? ☐ Yes ☐ No

If yes, expected delivery date: ___/___/______

Use the information provide by employer in Section I to answer this question. If the employer doesn't 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 or her job functions.

Is the employee unable to perform any of his or her job functions due to the condition? ☐ Yes ☐ No

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

____

____

3. 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

PART B: Amount of Leave Needed

4. Will the patient be incapacitated for a single continuous period of time due to his or her medical condition, including any time for treatment and recovery? ☐ Yes ☐ No

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

   During this time, will patient need care?: ☐ Yes ☐ No

5. Will the patient need to attend follow-up treatment including any time for recovery? Explain the care needed by the patient and why such care is medically necessary: ☐ Yes ☐ No

   ____

   ____

   If yes, are the treatments or the reduced number of hours of work medically necessary? ☐ Yes ☐ No

   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:

   ________ hours a day: ________ days a week from ________ through ______________

6. Will the condition cause episodic flare-ups periodically preventing the patient from performing his or her job functions? ☐ Yes ☐ No

   Is it medically necessary for the patient to be absent from work during the flare-ups? ☐ Yes ☐ No

   If yes, 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 six months (e.g., one episode every three months lasting one-two days):

   Frequency: ________ times a ________ week(s) ________ month(s

   Duration: ________ hours or ________ day(s) per episode

Continued On Next Page

Additional Information

(Identify question number with your additional answer.

Signature of Healthcare Provider

Date

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 20 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 Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**