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LEAVE MANAGEMENT SERVICES

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

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division, Revised 10/12

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of 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.

Employer name and contact: Leave Management Services Phone: 715-748-8115 Fax: 715-748-8832

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member and 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. 20 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

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 and estimate leave needed to provide care:

_____

_____

_____

_____ _____
Employee Signature Date

CONTINUED ON NEXT PAGE

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. 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 patient needs leave. Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice/ Medical specialty: _____

Telephone: (_____)_____Fax: (_____)_____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Was the patient admitted for an overnight stay at the hospital, hospice, or residential medical care facility?
   _____ No _____ Yes. If so, dates of admission:_____

   Date(s) you treated the patient for condition:_____

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

   Will the patient need to have treatment visits at least twice per year due to the condition? ____ 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. 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):

_____

_____

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care.

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

   Estimate the beginning and ending dates for the period of incapacity:_____

   During this time, will the patient need care? _____ No _____ Yes.

   Explain the care needed by the patient and why such care is medically necessary:_____

   _____

   _____

CONTINUED ON NEXT PAGE

5. 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:

   _____

   Estimate the care needed by the patient, and why such care is medically necessary:_____

   _____

6. 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 _____

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

   _____

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

   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

   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:_____

   _____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER

_____

_____

_____ _____

Signature of Health Care 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 PATIENT.

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 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.

Leave Management Services, 135 S. Gibson St., Medford, WI 54451 E-mail: leavemanagementservices@aspirus.org Phone: 715-748-8115 Fax: 715-748-8832