Instructions for Employee & Health Care Provider

Instructions for Employee

- Please bring the attached Certification for Health Care Provider form, a copy of your job description, and a copy of your work schedule to your health care provider
- Failure to provide a complete and sufficient medical certification may result in the denial of your FMLA request
- You must return the completed Certification for Health Care Provider form (or a sufficient alternative) within 15 calendar days
- The due date for the return of completed Certification for Health Care Provider form is listed at the top of the certification and on the Notice of Eligibility letter given to you by your department's HR Liaison

Instructions for Health Care Provider

- Answer, fully and completely, all applicable parts of the attached Certification for Health Care Provider form
- Terms such as "**lifetime**," "**unknown**," "**ongoing**," and "**to be determined**" may not be sufficient to determine FMLA coverage
- If information such as end dates are not yet determined, you may use a follow up appointment date until it is known
- If information such as the frequency and/or duration of treatment/appointments and/or episodes of incapacity are not yet known, please use your medical expertise and knowledge of the patient's condition to provide a best estimate
- You may revise your estimate of treatment/appointments and/or episodes of incapacity at any time
- A medical diagnosis is **NOT** required
- Limit your responses to the condition for which the employee is seeking leave
- If multiple unrelated conditions exist **and** require leave, those conditions will each require a separate certification on a separate form (please specify which form pertains to each condition; conditions may be numbered to differentiate if so desired: Condition 1, Condition 2, etc.)
- Do **NOT** provide information about genetic tests, genetic services, of the manifestation of disease or disorder in the employee's family members
- Please be sure to sign the form on the last page
- **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION**

FMLA Certification for Health Care Provider

Patient Name: Patient Date of Birth: Requested Frequency:	Employee work schedule: Paperwork Due Date:

PART A: MEDICAL FACTS

The patient's condition is (check as applicable): ☐ Pregnancy | ☐ Maternity | ☐ Related Condition(s)

OPTIONAL – List any relevant medical facts related to the condition for which the employee is seeking leave. Such facts may include symptoms, continued regimen of treatment, use of special equipment, diagnosis, etc.:

____

REQUIRED – Review and answer the below based upon the employer-provided work schedule or the employee's own description of their typical work schedule if none provided.

Is the employee unable to perform any of their job functions due to the condition? ☐ **YES** | ☐ **NO**

Identify the job functions the employee is unable to perform: ______________________________

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DUE DATE – Required

Estimated Date of Delivery: ______________________ ***(MM/DD/YYYY)***

Confirmed Date of Delivery (if known): ______________________ ***(MM/DD/YYYY)***

Complicated Pregnancy: ☐ **YES** | ☐ **NO**

Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. §1635.3(b).

Patient Name:
Patient Date of Birth: Paperwork Due Date:

PART B: AMOUNT OF LEAVE NEEDED

☐ **<u>Continuous Leave:</u>** Will the employee be incapacitated for a single continuous period of time due to their condition, including any time for treatment and recovery? ☐ **YES |** ☐ **NO**

If yes: Estimated Start Date ____________________ *(MM/DD/YYYY)*

Estimated End Date ____________________ *(MM/DD/YYYY)*

A follow up appointment date may be used if end date is unknown

Will the employee require intermittent leave or reduced schedule? If so, provide the relevant information below.

☐ **<u>Intermittent Leave:</u>**

Start date/initial appointment date: _______________*(MM/DD/YYYY)*
Estimated end date: ________________*(MM/DD/YYYY)*

- Will the employee need to attend treatments/appointments due to their condition? ☐ **YES |** ☐ **NO**
- Is the employee expected to only require the routine schedule of prenatal treatments/appointments? ☐ **YES |** ☐ **NO**
  If yes, please indicate the estimated duration of a standard treatment/appointment (including recovery and commute):
  <u>EACH</u> lasting up to ______ hours **OR** ______ days

<u>Estimated</u> non-standard treatment/appointment schedule:
Up to ______ per **DAY | WEEK | MONTH | YEAR *(circle one)***

<u>EACH</u> lasting up to ______ hours **OR** ______ days (including recovery and commute)
Future treatment/appointment dates: _______________________________

____

- Will the condition cause episodic flare-ups preventing the employee from performing their job functions? ☐ **YES |** ☐ **NO**

<u>Estimated</u> frequency & duration of episodes/flares:
Up to ______ per **DAY | WEEK | MONTH | YEAR *(circle one)***

<u>EACH</u> lasting up to ______ hours **OR** ______ days

Dates you have already treated the employee for this condition:

____

☐ **<u>Reduced Schedule:</u>**

Start Date: _______________*(MM/DD/YYYY)*
End Date: ________________ *(MM/DD/YYYY)*

Review and answer the below based upon the employer-provided work schedule or the employee's own description of their typical work schedule if none provided.

Provide the days and number of hours the employee **<u>CAN</u>** work *(not to include their lunch break).* If the employee is to be scheduled off, please indicate below.

SUNDAY ____________ hours **|** ☐ OFF

MONDAY ____________ hours **|** ☐ OFF

TUESDAY ____________ hours **|** ☐ OFF

WEDNESDAY ___________ hours **|** ☐ OFF

THURSDAY ____________ hours **|** ☐ OFF

FRIDAY ____________ hours **|** ☐ OFF

SATURDAY ____________ hours **|** ☐ OFF

Notes:

REQUIRED – Health Care Provider Contact & Signature:

Provider's Printed Name & Credentials:

Provider Address:

Provider Signature:

Provider Telephone #:

Date:

Provider Fax #:

Type of Practice/Specialty:

Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. §1635.3(b).