Certification of Health Care Provider for Family Member's Serious Health Condition(FMLA)

Section I: For Completion by the Employer:

Employer name and contact

Section II: For Completion by Employee

Please complete Section II 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 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 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 employer. 29C.F.R. 825.305.

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

Section III: For Completion by the Health Care Provider

The employee listed above has requested leave under the FMLA to care for your patient. Please provide the requested information below and respond to the frequency or duration of a condition, treatment, etc. Be specific and limit your responses to the condition for which the patient needs leave. Please be sure to sign and date the form.

Provider's name and business address:

Type of practice/Medical specialty:

Telephone: **Fax:**

Approximate Date patient's condition commenced:

Probable Duration of patient's condition:

Was 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 the condition:

Description of appropriate medical facts sufficient to support the need for leave and including information on symptoms, diagnosis, hospitalization, doctors visits, medications, and any necessary referrals for evaluation or treatment. When providing this information keep in mind your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or for the provision of physical or psychological care. Explain the care needed by the patient and why such care is medically necessary and whether the care is continuous or intermittent:

Signature of Health Care Provider: Date: