

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



**EMPLOYEE NAME:** \_\_\_\_\_ **EMPLOYEE ID/SSN:** \_\_\_\_\_

**CASE NUMBER:** \_\_\_\_\_ **EMPLOYER NAME:** \_\_\_\_\_

**For Completion by the HEALTH CARE 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 and business address: \_\_\_\_\_

Type of practice / Medical specialty: \_\_\_\_\_

Telephone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

**PART A: MEDICAL FACTS**

1. Approximate date condition commenced: \_\_\_\_\_

Probably duration of condition: \_\_\_\_\_

**Mark below as applicable:**

Was the 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 condition:

\_\_\_\_\_

Will the patient need to have treatment visits at least twice per year due to the condition? \_\_\_\_ No \_\_\_\_ Yes.

Was medication, other than over-the-counter medication, prescribed? \_\_\_\_ 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. Use the information provided by the employer to answer this question. If the employer fails to 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/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition: \_\_\_\_\_ No \_\_\_\_\_ Yes.

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

\_\_\_\_\_

4. 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):

**NOTE: In California, do not disclose the underlying diagnosis unless you have received consent from the patient**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PART B: AMOUNT OF LEAVE NEEDED**

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? \_\_\_\_\_ No \_\_\_\_\_ Yes.

If so, estimate the beginning and ending dates for the period of incapacity: \_\_\_\_\_

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? \_\_\_\_\_ No \_\_\_\_\_ yes.

If so, are the treatments or the reduced number of hours of work medically necessary? \_\_\_\_\_ 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 part-time or reduced work schedule the employee needs, if any: \_\_\_\_\_ hour(s) per day;

\_\_\_\_\_ days per week from \_\_\_\_\_ through \_\_\_\_\_

