

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



EMPLOYEE NAME: _____ **EMPLOYEE ID/SSN:** _____

CASE NUMBER: _____ **EMPLOYER NAME:** _____

For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete this section 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. 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 employer. 29 C.F.R. § 825.305.

Return a complete and sufficient medical certification to:

Sedgwick CMS
P.O. Box 9830
Calabasas, CA 91372-0830
Fax: 818-591-7664

Name of family member for whom you will provide care:

First	Middle	Last
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Relationship of family member to you:

Spouse Father Mother Son Daughter Other: _____

If family member is your father, mother, son or daughter, what is their date of birth: _____

Describe the care you will provide to your family member and estimate the amount of leave needed to provide care:

Employee Signature

Date

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 care. The last page provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name: _____

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 in a 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 patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

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

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:

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:

Explain 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