CERTIFICATION OF HEALTH CARE PROVIDER
FAMILY MEMBER'S SERIOUS HEALTH CONDITION
(*FAMILY AND MEDICAL LEAVE – AM-203-2-5*)

Section I: To be Completed by the Employee

Employee's Full Name ______________________ Job Title ______________________

Agency/Bureau/Division ______________________

Regular Work Schedule ______________________

Phone ______________________ Email ______________________

Name of family member for whom care will be provided ______________________

The family member is the employee's:

☐ Parent ☐ Spouse ☐ Child (Specify date of birth):______________________

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

I affirm that, to the best of my knowledge, the above information contains no false or misleading statements.

Employee Signature ______________________ Date ______________________

Section II: To be Completed by the Health Care Provider

The employee listed in Section I has requested leave under the *Family and Medical Leave Act* (FMLA) to care for your patient. Please answer the questions in this certification form fully and completely. Make sure to sign the last page. Several questions ask you to describe the frequency or duration of a condition, treatment, etc. You should provide your best estimate, based upon your medical knowledge, experience and examination of the patient. Please 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.

Health Care Provider's Name ______________________ Name of Practice/Health Care Facility ______________________

Business Address ______________________

Type of Practice/Specialty ______________________

Phone ______________________ Fax ______________________

Section II, Part A: Medical Facts

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?..... ☐ Yes ☐ No

If yes, please provide dates of admission:

______________ ______________ ______________ ______________

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

______________ ______________ ______________ ______________

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

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

Was the patient referred to other health care provider(s) for evaluation or treatment? .... ☐ Yes ☐ No
(*e.g., physical therapist, etc.*)

If yes, state the nature of such treatments and expected duration of treatment:

Is the medical condition pregnancy?.. ☐ Yes ☐ No

If yes, please provide expected delivery date:__________________________

Describe other relevant medical facts related to the condition for which the employee seeks leave:
(*Such medical facts may include, for example, symptoms, diagnosis and any regimen of continuing treatment.*)

Section II, Part B: Amount of Care Needed

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

If yes, estimate the beginning and ending dates for the period of incapacity:

Beginning Date ______________________ Ending Date ______________________

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

If yes, explain the care needed by the patient and why such care is medically necessary:

Will the employee need to be absent from work intermittently in order to provide care for the patient? .... ☐ Yes ☐ No

If yes, explain the intermittent care needed by the patient, why intermittent care is medically necessary and for how long the employee will need to provide care on an intermittent basis:

Will the patient require follow-up treatment or appointments? .... ☐ Yes ☐ No

If yes, estimate the treatment schedule, including the dates or frequency of any scheduled appointments and the time required for each appointment, including any recovery period:

Please explain the follow-up care needed by the patient and why such care is medically necessary:

Will the condition cause episodic flare-ups, preventing the patient from participating in normal activities? .. ☐ Yes ☐ No

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 experience over the next 6 months (*e.g., 1 episode every 3 months, lasting 1-2 days*):

Frequency:______________times per every______________week(s)/______________month(s)

Duration:______________hours OR______________day(s) per episode

Will the patient need care during these flare-ups?.. ☐ Yes ☐ No

Explain the care needed by the patient during flare-ups and why such care is medically necessary:

Will the employee need to work a part-time or reduced work schedule in order to care for the patient? .... ☐ Yes ☐ No

If yes, explain the care needed by the patient, why a part-time or reduced work schedule is medically necessary for the patient and for how long the schedule will be required:

Estimate the reduced work schedule:

_____________hours per day,_______________days per week

Section II, Part C: Additional Information

Please provide any additional information relevant to the condition for which the employee is requesting leave. Attach additional sheets if necessary.

Section III: Health Care Provider Verification

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Signature of Health Care Provider Date