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

U.S. Department of Labor
Wage Hour Division

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR . RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
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The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave to care for a family member with a serious health condition to submit a medical certification issued by the family member's health care provider. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee at least 15 calendar days to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. An employer may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306, 825.308.

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employee when the employee was a child. An employee may also take FMLA
ee has assumed the obligations of a parent. No legal or biological relationship

Employee Name: _____

(3) Briefly describe the care you will provide to your family member. (Check all that apply)

Assistance with basic medical, hygienic, nutritional, or safety needs Transportation

Physical Care Psychological Comfort Other: _____

(4) Give your best estimate of the amount of leave needed to provide the care described: _____

_____

(5) If a reduced work schedule is necessary to provide the care described, give your best estimate of the reduced schedule you are able to work. From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy), I am able to work _____ (hours per day) by _____ days per week)

Employee
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Employee Name: _____

(5) Check the box(es) for the questions below as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

Inpatient Care: The patient (has been / is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____

Incapacity plus Treatment: (e.g. outpatient surgery, strep throat)
Due to the condition, the patient (has been / is expected to be) incapacitated for more than three consecutive, full calendar days from _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy).

The patient (was / will be) seen on the following date(s): _____

_____

The condition (has / has not) also resulted in a course of continuing treatment under the supervision of a health care provider (e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment).

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Employee Name: _____

(9) Due to the condition, the patient (was / will be) incapacitated for a continuous period of time, including any time for treatment(s) and/or recovery.

Provide your best estimate of the beginning date: _____ (mm/dd/yyyy) and end date _____ (mm/dd/yyyy) for the period of incapacity.

(10) Due to the condition it, (was / is / will be) medically necessary for the employee to be absent from work to provide care for the patient on an intermittent basis (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your best estimate of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur _____ times per (day / week / month) and are likely to last approximately _____ hours / days) per episode

Signature of
Health Care Provider _____ Date _____ (mm/dd/yyyy)

Definitions
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_____
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