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Department of Human Resources

MEDICAL CERTIFICATION STATEMENT
(ILLNESS OF **EMPLOYEE'S FAMILY MEMBER**)

SECTION I: To Be Completed by the EMPLOYEE:

Please complete Section I 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. 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 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. 29 C.F.R. § 825.305.

Employee's 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: _____/_____/_____ **

**If your son or daughter is over the age of 18, the Supplemental Documentation - Adult Child form is REQUIRED in addition to this form.*

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

_____

_____

_____

_____ _____

Employee's Signature **Date**

SECTION II: To Be Completed by 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 employee is seeking leave. Please be sure to sign the form on the last page.

Healthcare Provider's Name and Business Address:

_____

Type of Practice/Medical Specialty: _____

Telephone: (____) _____ Fax: (____) _____ Email: _____

SECTION II (cont'd): To Be Completed by the HEALTH CARE PROVIDER:

- **Serious Health Condition**: The attached sheet describes a "**serious health condition**". Does the condition qualify under any one of the categories described? If so, check the applicable category.

  (1) ☐ (2) ☐ (3) ☐ (4) ☐ (5) ☐ (6) ☐ or None of the above ☐

  Describe the **specific medical facts** which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

  _____
  _____
  _____
  _____
  _____
  _____
  _____
  _____
  _____

I. Date condition began: _____

Date condition ended (or is expected to end): _____

II. Explanation of extent to which employee is needed to care for the ill spouse, child or parent:

_____
_____
_____

- Does the family member require **assistance for basic medical or personal needs or safety**, or for **transportation**? ☐ Yes ☐ No

- Would the employee's presence to provide **psychological comfort** be beneficial to the family member or assist in their recovery? ☐ Yes ☐ No

III. Will it be necessary for the **employee to work intermittently or to work on less than a full schedule** due to the family member's condition? ☐ Yes ☐ No

a. If **YES**, please state the probable duration **and the amount of time off** from work for the employee:

_____

b. If the condition is a **chronic condition** or **pregnancy,** state whether the family member is presently incapacitated and the likely **duration and frequency of episodes (flare-ups)** of incapacity:

_____
_____

Estimate **frequency** of flare-ups and **duration** of incapacity over next 6 months:

Frequency: _____times per _____weeks(s) _____month(s)

Duration: _____hours or _____day(s) per episode

SECTION II (cont'd): To Be Completed by the HEALTH CARE PROVIDER:

c. If **additional treatments** are required for the condition, provide an **estimate of the probable number** and **interval between such treatments**, **actual or estimated dates of treatment**, if known, and **period of recovery**, if any?

_____
_____
_____
_____

_____ _____

Health Care Provider Signature **Date**

An employer may contact an employee's health care provider for authentication or clarification of the medical certification by using a health care provider, a human resource professional, or a management official. In no case may the employee's direct supervisor contact the employee's health care provider. Employers may not ask the health care provider for additional information beyond that contained on the medical certification form.

A **"Serious Health Condition"** means an illness, injury impairment, or physical or mental condition that involves one of the following:

1. ***Hospital Care:***
   Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity[1] or subsequent treatment in connection with or consequent to such inpatient care.

2. ***Absence Plus Treatment:***
   (a) A period of incapacity[1] of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity[1] relating to the same condition), that also involves:
   (1) **Treatment**[2] **two or more times** by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or

   (2) **Treatment** by a health care provider on **at least one occasion** which results in a **regimen of continuing treatment**[3] under the supervision of the health care provider.

3. ***Pregnancy:***
   Any period of incapacity due to **pregnancy**, or for **prenatal care**

4. ***Chronic Conditions Requiring Treatments:***
   A **chronic condition** which:
   (1) Requires **periodic visits** for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider;
   (2) Continues over an **extended period of time** (including recurring episodes of a single underlying condition); and
   (3) May cause **episodic** rather than a continuing period of incapacity[1] (e.g., asthma, diabetes, epilepsy, etc.).

5. ***Permanent/Long-Term Conditions Requiring Supervision:***
   A period of **Incapacity**[1] which is **permanent or long-term** due to a condition for which treatment may not be effective. The employee or family member must be **under the continuing supervision of, but need not be receiving active treatment by, a health care provider**. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. ***Multiple Treatments (Non-Chronic Conditions):***
   Any period of absence to receive **multiple treatments** (including any period of recovery there from) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for **restorative surgery** after an accident or other injury, **or** for a condition that **would likely result in a period of Incapacity**[1] **of more than three consecutive calendar days in the absence of medical intervention or treatment**, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), and kidney disease (dialysis).

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[1] "Incapacity," for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery there from.

[2] Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

[3] A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.