CERTIFICATION OF HEALTH CARE PROVIDER
EMPLOYEE'S SERIOUS HEALTH CONDITION
(*FAMILY AND MEDICAL LEAVE – AM-203-2-4*)

Section I: To be Completed by the Employee

Employee's Full Name ____________________ Job Title ____________________

Agency/Bureau/Division ____________________

Regular Work Schedule ____________________

Phone ____________________ Email ____________________

Section II: To Be Completed by the Health Care Provider

Your patient has requested leave under the *Family and Medical Leave Act* (FMLA). 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.

The *Genetic Information Nondiscrimination Act* (GINA) prohibits employers from requesting or requiring genetic information of an individual or a family member of the individual, except as specifically allowed by law. In order to comply, we are asking that you not provide any genetic information when completing this medical certification. GINA defines "genetic information" to include family medical history, the results of genetic tests, the fact that an individual or family member has requested or received genetic services or the genetic information of a fetus or embryo.

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:

____________________ ____________________ ____________________

Dates 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:____________________

Is the employee unable to perform any of his/her job functions due to the condition? .... ☐ Yes ☐ No

If yes, identify the job functions the employee is unable to perform and specify the probable duration:

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 Leave Needed

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? .... ☐ Yes ☐ No

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

______________________	______________________
Beginning Date	Ending Date

Is it medically necessary for the employee to take leave intermittently?.. ☐ Yes ☐ No

If yes, explain why and state the probable frequency/duration of intermittent absences:

Will the employee need to attend follow-up treatment appointments?.. ☐ Yes ☐ No

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

Will the condition cause episodic flare-ups? .... ☐ Yes ☐ No

If yes, is it medically necessary for the employee to be absent from work during flare-ups?.................. ☐ Yes ☐ No

Please explain:

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

Is it medically necessary for the employee to work a part-time or reduced work schedule?.......................... ☐ Yes ☐ No

If yes, explain why and for how long:

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

Signature of Health Care Provider

Date