

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

## **SECTION I: For Completion by the EMPLOYER**

**INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer Name: <b>MORGAN STATE UNIVERSITY</b>	
Employer Contact: <b>OFFICE OF HUMAN RESOURCES – (443) 885-3195</b>	
Employee's Job Title:	Regular Work Schedule:
Employee's Essential Job Functions:	

Check if job description is attached:

## **SECTION II: For Completion by the EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II before giving this form to your 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 due to your own 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. 20 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(b).

Your Name:

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First
Middle
Last

**SECTION III: For Completion by the HEALTH CARE PROVIDER**

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. 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.

Provider’s Name and Business Address:	Type of Practice/Medical Specialty:
Telephone:	Fax:

**PART A: MEDICAL FACTS**

1. Approximate date condition commenced: \_\_\_\_\_

Probable duration of condition: \_\_\_\_\_

**Mark below as applicable:**

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?      No      Yes

If yes, dates of admission: \_\_\_\_\_

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

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

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

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

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

2. Is the medical condition pregnancy?      No      Yes  
If yes, expected delivery date: \_\_\_\_\_

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee’s essential functions or a job description, answer these questions based upon the employee’s own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition?

No                       Yes

If yes, identify the job functions the employee is unable to perform:

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

**PART B: AMOUNT OF LEAVE NEEDED**

5. 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?       No               Yes  
If yes, estimate the beginning and ending dates for the period of incapacity:

Beginning Date: \_\_\_\_\_      Ending Date: \_\_\_\_\_

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition?       No               Yes  
If yes, are the treatments or the reduced number of hours of work medically necessary?  
 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:

Estimate the part-time or reduced work schedule the employee needs, if any:

\_\_\_\_\_ hour(s) per day, \_\_\_\_\_ days per week from \_\_\_\_\_ through \_\_\_\_\_ .

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions?       No               Yes

Is it medically necessary for the employee to be absent from work during the flare-ups?

No     Yes    If yes, explain:

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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

**ADDITIONAL INFORMATION:**

IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

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\_\_\_\_\_  
Signature of Health Care Provider

\_\_\_\_\_  
Date

**DO NOT SEND COMPLETED FORM TO THE EMPLOYER;  
RETURN TO THE PATIENT.**

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

## **SECTION I: For Completion by the EMPLOYER**

**INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer Name and Contact:

**MORGAN STATE UNIVERSITY – OFFICE OF HUMAN RESOURCES – (443) 885-3195**

## **SECTION II: For Completion by the EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II 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 to your employer. 29 C.F.R. § 825.305.

Your 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:	

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

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**Employee Signature**

**Date**

**SECTION III: 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 leave. Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

**Provider’s Name and Business Address:**

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**Type of Practice/Medical Specialty:**

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**Telephone:** ( \_\_\_\_\_ ) \_\_\_\_\_

**Fax:** ( \_\_\_\_\_ ) \_\_\_\_\_

**PART A: MEDICAL FACTS**

**1. Approximate date condition commenced:** \_\_\_\_\_

**Probable duration of condition:**

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**Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?**

No       Yes      **If so, dates of admission:**

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

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**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:**

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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):

**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:

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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**

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Signature of Health Care Provider

Date

**DO NOT SEND COMPLETED FORM TO THE EMPLOYER; RETURN TO THE PATIENT.**