Certification of Health Care Provider for Employee's Serious Health Condition (FMLA)

Section I: For Completion by the Employer

Employer name and contact: _____ _____

Employee's job title: _____ **Regular Work Schedule** _____

Employee's essential job functions: _____

_____ **Check if Job Description attached** ☐

Section II: For Completion by 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 denial of your FMLA request. Your employer must give you at least 15 calendar days to return this form 29 C.F.R. 825.305 (b).

Your Name: _____ _____ _____

First Middle Last

Section III: For Completion by the Health Care Provider

Your patient has requested leave under the FMLA. Please provide the requested information below and respond to the frequency or duration of a condition, treatment, etc. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign and date the form.

Provider's name and business address: _____

Type of practice/Medical specialty: _____

Telephone: _____ **Fax:** _____

Approximate Date patient's condition commenced: _____

Probable Duration of patient's condition: _____

Was patient admitted for an overnight stay in a hospital, hospice or residential medical care facility?
☐ No ☐ Yes. If so, dates of admission: _____
Date(s) you treated the patient for the condition: _____
Description of appropriate medical facts sufficient to support the need for leave and including information on symptoms, diagnosis, hospitalization, doctors visits, medications, and any necessary referrals for evaluation or treatment. This information must also contain sufficient information to establish that the employee cannot perform the essential functions of his/her job including work restrictions and the likely duration of such inability:

Signature of Health Care Provider: _____ Date: _____