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

U.S. Department of Labor Wage and Hour Division



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

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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. 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. You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Additionally, you may not request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, 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, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

(1) Employee name:					
	First		Middle	Last	
(2) Employer name:	NFTA	Attn: Michelle	Fx: 716-855-7336	Date:	(mm/dd/yyyy)
				(List date certification requested))
(3) The medical certifi	cation must be	returned by			(mm/dd/yyyy)
(Must allow at least	15 calendar day	rs from the date requested, unles	s it is not feasible despite the emplo	yee's diligent, good faith efforts.)	, , , , , , , , , , , , , , , , , , , ,
(4) Employee's job title:				_ Job description _ is / _ is	not attached.
Employee's regula	r work schedul	e:			
Statement of the e	mployee's ess	ential job functions:			
,		oyee's position are determined w e leave started, whichever is earl	·	loyee held at the time the employee n	otified the

SECTION II - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient has requested leave under the FMLA. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of the employee. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves **inpatient care** or **continuing treatment by a health care provider**. For more information about the definitions of a serious health condition under the FMLA, see the chart on page 4.

You also may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

Employee Name:		
Health Care Provider's name: (Print)		
Health Care Provider's business address:		
Type of practice / Medical specialty:		
Telephone:	Fax:	E-mail:
PART A: Medical Information		
based upon your medical knowledge, exinformation about the amount of leave regular daily activities due to the condition	xperience, and exam needed. Note: For F n, treatment of the co n, genetic services, as	e employee is seeking FMLA leave. Your answers should be your best estimate nination of the patient. After completing Part A, complete Part B to provide FMLA purposes, "incapacity" means the inability to work, attend school, or perforn ondition, or recovery from the condition. Do not provide information about genetics defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in
(1) State the approximate date the condition	on started or will star	rt: (mm/dd/yyyy)
(2) Provide your best estimate of how lon	ng the condition lasted	d or will last:
Inpatient Care: The patient (has been / is exp	For all box(es) checked, the amount of leave needed must be provided in Part B. spected to be) admitted for an overnight stay in a hospital, bwing date(s):
Incapacity plus Treatment: (e.g.	outpatient surgery, s	strep throat)
consecutive, full calendar days from	om:	is expected to be) incapacitated for more than three (mm/dd/yyyy) to (mm/dd/yyyy). wing date(s):
		n a course of continuing treatment under the supervision of a er than over-the-counter) or therapy requiring special equipment).
Pregnancy: The condition is pregnancy:	nancy. List the exp	pected delivery date: (mm/dd/yyyy).
Chronic Conditions: (e.g. asthmatreatment visits at least twice per y		es) Due to the condition, it is medically necessary for the patient to have
		er's, terminal stages of cancer) Due to the condition, incapacity is permanent f a health care provider (even if active treatment is not being provided).
Conditions requiring Multiple Tr		motherapy treatments, restorative surgery) Due to the condition, it is medically s.
None of the above: If none of the needed. Go to page 4 to sign and		were checked, (i.e., inpatient care, pregnancy) no additional information is

Employee Name:
(4) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. (e.g., use of nebulizer, dialysis)
PART B: Amount of Leave Needed
For the medical condition(s) checked in Part A, complete all that apply. 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.
(5) Due to the condition, the patient (had / will have) planned medical treatment(s) (scheduled medical visits) (e.g.psychotherapy, prenatal appointments) on the following date(s):
(6) Due to the condition, the patient (was / will be) referred to other health care provider(s) for evaluation or treatment(s).
State the nature of such treatments: (e.g. cardiologist, physical therapy)
Provide your best estimate of the beginning date (mm/dd/yyyy) and end date (mm/dd/yyyy).
for the treatment(s).
Provide your best estimate of the duration of the treatment(s), including any period(s) of recovery (e.g. 3 days/week)
(7) Due to the condition, it is medically necessary for the employee to work a reduced schedule .
Provide your best estimate of the reduced schedule the employee is able to work. From (mm/dd/yyyy)
to (mm/dd/yyyy) the employee is able to work: (e.g., 5 hours/day, up to 25 hours a week)
(8) 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.
(9) Due to the condition, it (was / size is / will be) medically necessary for the employee to be absent from work 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.

Employee Name:		
PART C: Essential Job Functions		
If provided, the information in Section I question #4 may be used to answer employee's essential functions or a job description, answer these questions functions. An employee who must be absent from work to receive medical the condition is considered to be not able to perform the essential job functions of	s based upon the employee's own description of treatment(s), such as scheduled medical visits, for	the essential job
(10) Due to the condition, the employee (was not able / is not able /	will not be able) to perform one or more of t	he
essential job function(s). Identify at least one essential job function the emplo	yee is not able to perform:	
Signature of Health Care Provider	Date:	(mm/dd/yyyy
Definitions of a Serious Health Condition (See 29 C.F.R. §§ 825.1	3115)	
Inpatient Care		
 An overnight stay in a hospital, hospice, or residential medical ca Inpatient care includes any period of incapacity or any subseque 	•	stay.
Continuing Treatment by a Health Care Provider (any one or more	of the following)	
Incapacity Plus Treatment : A period of incapacity of more than three treatment or period of incapacity relating to the same condition, that a		sequent
o Two or more in-person visits to a health care provider for tre extenuating circumstances exist. The first visit must be with		
 At least one in-person visit to a health care provider for trea results in a regimen of continuing treatment under the supe provider might prescribe a course of prescription medicatio 	rvision of the health care provider. For examp	
Pregnancy: Any period of incapacity due to pregnancy or for prenata	l care.	
Chronic Conditions : Any period of incapacity due to or treatment for asthma, migraine headaches. A chronic serious health condition is on supervised by the provider) at least twice a year and recurs over an episodic rather than a continuing period of incapacity.	e which requires visits to a health care provide	er (or nurse
Permanent or Long-term Conditions : A period of incapacity which treatment may not be effective, but which requires the continuing sup disease or the terminal stages of cancer.		
Conditions Requiring Multiple Treatments : Restorative surgery aft likely result in a period of incapacity of more than three consecutive, f		

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 15 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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