# Family and Medical Leave Act (FMLA)

## Certification of Health Care Provider for care of a family member with a Serious Health Condition

***Note: Failure to fully complete this form could result in an initial denial of an FMLA leave or delay in approval of an FMLA Leave for the employee.*** *The information sought relates only to the family member's condition for which the employee is taking FMLA leave. Where the need is foreseeable, an employee must provide at least 30 days advance notice of the need for leave, whenever possible.*

**SECTION I: For Completion by the EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section I before giving this form to your family member's medical provider. The FMLA permits NHRMC to require that you submit a timely, complete, and sufficient medical certification to support a request for medical leave due to the serious health condition of a family member. Your response is required to obtain or retain the benefit of FMLA protection. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. You have 15 calendar days to return this form.

IMPORTANT: In the case of an incomplete, vague or non-responsive medical certification, NHRMC HR Benefits may notify you in writing of the additional information/clarification that is necessary to complete the certification. You then have seven calendar days to provide the requested information. If you fail to submit a complete and sufficient certification despite the opportunity to correct it, we may deny the FMLA leave.

Your name: _____
First Middle Last

Your Job Title: _____ Your regular work schedule: _____

Name of family member for whom you will provide care (first, middle, last):_____

Relationship of family member to you:_____ If family member is your child, give us the date of birth:_____

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

_____

_____

**NHRMC Benefit Contacts:**

Katie Roy
Sr, Benefit Administrator, A-E
910.815.5234 phone
910.815.5969 fax
katie.roy@nhrmc.org

Hilary Kovach
Benefit Administrator, F-P
910.815.5330 phone
910.815.5969 fax
hilary.kovach@nhrmc.org

Shannon Hoffman
Sr. Benefit Administrator, Q-Z
910.815.5262 phone
910.815.5969 fax
shannon.hoffman@nhrmc.org

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

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** The employee listed above has requested leave under FMLA to care for your patient. 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 patient may need help from the employee requesting leave. Please be sure to sign the form on the last page. **PRINT CLEARLY**

**Dr.'s name & Provider's name, Business address:** _____

**Type of practice/medical specialty:** _____

**Telephone:** (_____)_____ **Fax:**(_____)_____

## PART A: MEDICAL FACTS (PRINT CLEARLY FOR TIMELY PROCESSING)

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 so, 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 so, state the nature of such treatments and expected duration of treatment: Print Clearly.

   _____

   _____

2. Is the medical condition pregnancy?

   _____No _____Yes. If so, expected delivery date: _____

3. **REQUIRED:** Describe the relevant medical facts, 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): Print Clearly.

   _____

   _____

   _____

## 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:

1. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery?

   _____No _____Yes.

   If so, estimate the beginning and ending dates for the period of incapacity: _____.

2. During this time, will the patient need care?

   _____No _____Yes.

If yes, explain the care needed by the patient and why such care is medically necessary:

_____

_____

3. Will the patient require follow-up treatments, including any time for recovery?

_____No _____Yes.

If so, 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 care needed by the patient and why such care is medically necessary: _____

_____

4. 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;

How many _____ days per week? From (start date) _____ Through (end date)_____

Estimate the care needed by the patient and why such care is medically necessary: _____

_____

5. 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). **This information is <u>REQUIRED</u> and is only an "estimate" to determine if the specifics of the need fall under the criteria of Intermittent FMLA.**

**MUST BE COMPLETED**: Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or _____ day(s) per episode

Explain the care needed by the patient and why such care is medically necessary: _____

_____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER. Print Clearly.

_____

_____

_____

_____ _____

**Signature of Health Care Provider** **Date**