Family and Medical Leave Act (FMLA)

Certification of Health Care Provider for Employees 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 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 your own serious health condition. 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: _____

NHRMC Benefit Contacts:

Katie Roy	Hilary Kovach	Shannon Hoffman
Sr. Benefit Administrator, A-E	Benefit Administrator, F-P	Sr. Benefit Administrator, Q-Z
910.815.5234 phone	910.815.5330 phone	910.815.5262 phone
910.815.5969 fax	910.815.5969 fax	910.815.5969 fax
katie.roy@nhrmc.org	hilary.kovach@nhrmc.org	shannon.hoffman@nhrmc.org

SECTION II: 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.
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. Use the information provided in Section I to answer this question. If there is no job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee **ABLE** to perform any of his/her job functions due to the condition:

_____No _____Yes.

If **NO**, identify the job functions the employee is unable to perform: Print Clearly.

_____

_____

_____

_____

4. **REQUIRED:** Describe 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 LEAVE NEEDED

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

2. 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 so, 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 _____

3. 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 so, 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 have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days) **This information is REQUIRED 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

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

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider **Date**