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.

Employer name and contact: _____________________________________

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. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. It is your responsibility to ensure that the health care provider returns the completed form to you or Employee Health via fax# 205 996-9274 within 15 calendar days of receipt.

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:
________________________________________
________________________________________
________________________________________
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. Do not provide information about genetic tests or genetic services. Page 2 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: __________________________________________
(Please Print)
Type of practice / Medical specialty: __________________________________________
Telephone: (______)________________________ Fax:(______)________________________

PART A: MEDICAL FACTS

1. Approximate date condition commenced: __________________________
Probable duration of condition: __________________________
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: __________________________________________

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

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: __________________________

   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, the time required for each appointment, the care needed by the patient, and why such care is medically necessary including any recovery period:

   __________________________

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:

   ____________________________________________________________

   ____________________________________________________________

   ____________________________________________________________

   ____________________________________________________________

   ____________________________________________________________

   ____________________________________________________________

   ____________________________________________________________

Signature of Health Care Provider _______________________________________ Date ____________________