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# 205 975-6900 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, genetic services, or the manifestation of disease or disorder in the employee's family members. 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