FMLA MEDICAL CERTIFICATION FOR EMPLOYEE

PART ONE: To be completed by Employee requesting FMLA

I am requesting FMLA leave due to my own serious health condition. Per the Family and Medical Leave Act of 1993 a "serious medical condition" is defined as an illness, injury, impairment or physical or mental condition that involves inpatient care in a hospital, hospice or residential medical care facility; or any period of incapacity requiring absence from work for more thaln three (3) calendar days that involves continuing treatment from a health care provider. Or continuing treatment by a health care provider for a choronic or long-term health condition that is incurable or which, if left untreated, would result in a period of incapacity of more thaln three (3) calendar days; or prentatal care by a health care provider.

Employee Name: ______________________ Employee Job Title: _____________________________

Department/Divison: ___________________ Regular Work Schedule: __________________________

PART TWO: To be completed by Physician or Practitioner

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.

Provider's Name and Business address:
____

Phone Number : ________________________ Fax Number: _____________________________________

Type of Practice/Medical Specialty: ____

Part A: Medical Facts

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:
____

2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: ________________

3. Is the employee unable to perform any of their job functions due to the condition?
___No ___ Yes If so, please explain:

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4. Describe other relevant medical facts, if any, 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):

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Part B: Amount of Leave Needed

5. 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: _______________________

6. 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:

____

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Estimate the part-time or reduced work schedule the employee needs, if any: __________ hour(s) per

day; __________ days per week from _____________ ________through ______________________

7. 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):
Frequency: _____ times per _____ week(s)_____ month(s)
Duration: _____ hours or ___ day(s) per episode

ADDITIONAL INFORMATION/COMMENTS:
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_____________________________________ _________________________
Signature of Health Care Provider Date