Certification of Health Care Provider for Employee's Serious Health Condition under the Family and Medical Leave Act

U.S. Department of Labor
Wage and Hour Division

WAGE AND HOUR DIVISION

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.

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The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee at least 15 calendar days to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308.** Additionally, you **may not** request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

(1) Employee name: _____
First Middle Last

(2) Employer name: _____ Date: _____ (mm/dd/yyyy)
(List date certification requested)

(3) The medical certification must be returned by _____ (mm/dd/yyyy)
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

(4) Employee's job title: _____ Job description ☐ is / ☐ is not attached.

Employee's regular work schedule: _____

Statement of the employee's essential job functions:

_____

(The essential functions of the employee's position are determined with reference to the position the employee held at the time the employee notified the employer of the need for leave or the leave started, whichever is earlier.)

SECTION II - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient has requested leave under the FMLA. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of the employee. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves **inpatient care** or **continuing treatment by a health care provider**. For more information about the definitions of a serious health condition under the FMLA, see the chart on page 4.

You also may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

Employee Name: _____

Health Care Provider's name: (Print) _____

Health Care Provider's business address: _____

Type of practice / Medical specialty: _____

Telephone: _____ Fax: _____ E-mail: _____

PART A: Medical Information

Limit your response to the medical condition(s) for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

(1) State the approximate date the condition started or will start: _____ (mm/dd/yyyy)

(2) Provide your **best estimate** of how long the condition lasted or will last: _____

(3) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

☐ **Inpatient Care**: The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____

☐ **Incapacity plus Treatment**: (e.g. outpatient surgery, strep throat)

Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for **more than** three consecutive, full calendar days from: _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy).

The patient (☐ was / ☐ will be) seen on the following date(s): _____

_____

The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider (e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment).

☐ **Pregnancy**: The condition is pregnancy. List the expected delivery date: _____ (mm/dd/yyyy).

☐ **Chronic Conditions**: (e.g. asthma, migraine headaches) Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Permanent or Long Term Conditions**: (e.g. Alzheimer's, terminal stages of cancer) Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Conditions requiring Multiple Treatments**: (e.g. chemotherapy treatments, restorative surgery) Due to the condition, it is medically necessary for the patient to receive multiple treatments.

☐ **None of the above**: If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

Employee Name: _____

(4) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. (e.g., use of nebulizer, dialysis)

_____

PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. 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.

(5) Due to the condition, the patient (☐ had / ☐ will have) **planned medical treatment(s)** (scheduled medical visits) (e.g.psychotherapy, prenatal appointments) on the following date(s): _____

_____

(6) Due to the condition, the patient (☐ was / ☐ will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: (e.g. cardiologist, physical therapy) _____

Provide your **best estimate** of the beginning date _____ (mm/dd/yyyy) and end date _____ (mm/dd/yyyy). for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery (e.g. 3 days/week)

_____

(7) Due to the condition, it is medically necessary for the employee to work a **reduced schedule**.

Provide your **best estimate** of the reduced schedule the employee is able to work. From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy) the employee is able to work: (e.g., 5 hours/day, up to 25 hours a week)

_____

(8) Due to the condition, the patient (☐ was / ☐ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date _____ (mm/dd/yyyy) and end date _____ (mm/dd/yyyy). for the period of incapacity.

(9) Due to the condition, it (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work on an intermittent basis (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur _____ times per (☐ day ☐ week ☐ month) and are likely to last approximately _____ (☐ hours ☐ days) per episode.

Employee Name: _____

PART C: Essential Job Functions

If provided, the information in Section I question #4 may be used to answer this question. If the employer fails to provide a statement of the employee's essential functions or a job description, answer these questions based upon the employee's own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be **not able** to perform the essential job functions of the position during the absence for treatment(s).

(10) Due to the condition, the employee (☐ was not able / ☐ is not able / ☐ will not be able) to perform **one or more** of the essential job function(s). Identify at least one essential job function the employee is not able to perform:

_____

Signature of Health Care Provider _____ Date: _____ (mm/dd/yyyy)

Definitions of a Serious Health Condition (See 29 C.F.R. §§ 825.113-.115)
Inpatient Care
• An overnight stay in a hospital, hospice, or residential medical care facility. • Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.
Continuing Treatment by a Health Care Provider (any one or more of the following)
Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.
Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.
Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 15 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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Family and Medical Leave Act Certification of a Serious Health Condition

WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR

Help for Health Care Providers

The Family and Medical Leave Act (FMLA) provides critical protections to help workers balance the demands of the workplace with the needs of their families and their own health. The FMLA provides eligible employees the right to take up to **12 workweeks** of unpaid, job-protected leave for specified family and medical reasons with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave.

Health care providers can be important allies in helping employees obtain the necessary job protections afforded by the FMLA by timely and accurately completing requests for certification. This flyer outlines what health care providers need to know about FMLA and the steps they can take to make sure patients' and family caregivers' employment is protected during serious illness.

What You Should Know About FMLA Leave

- FMLA leave may be taken for a variety of reasons, including when the employee is unable to work because of **their own** serious health condition **and to care for their spouse, child or parent who has a serious health condition**.
- FMLA leave may be taken all at once or **intermittently or on a reduced leave schedule** if there is a medical necessity.
- Eligible employees can take up to 12 weeks of FMLA leave within a single 12-month period, or **leave year** (e.g., calendar year, fiscal year, employee anniversary date).
- An employer may require an employee seeking FMLA leave due to a serious health condition (their own or a family member's) to submit a **medical certification to verify the employee's need for time off**. The employer may not request a certification for leave to bond with a newborn child or a child placed for adoption or foster care.

Supporting FMLA Leave for Your Patient or Their Family Caregiver

Your patient or your patient's family caregiver might request one or more of the following to support their need for FMLA leave:

- **Medical certification** of whether your patient has a serious health condition and that your patient, or their family caregiver, may need FMLA leave (e.g., for treatment, recovery, or caregiving)
- **Recertification** of your patient's serious health condition during the same leave year, which an employee may need to obtain no more often than every 30 days for a short-term condition, after six months for a longer-term condition, or sooner if, for example, the medical circumstances have changed significantly
- **New medical certification** in new leave years if an employee's need for FMLA leave due to a serious health condition continues
- **Second or third medical opinions** if an employer has received a complete and sufficient certification but has a reason to doubt that it is valid
- **Fitness-for-duty certification** showing that your patient is able to resume work

You may be asked for additional information if the medical certification or recertification is incomplete, or if there is a need to clarify some of the information.

An employer might request that you—

- **Authenticate or clarify information received.** Once an employer has received a complete and sufficient medical certification, they may not request that an employee seek additional information from a health care provider. However, the employer may contact you to authenticate or clarify the information provided.
    - *You may be contacted by the employer's human resources staff, a leave administrator, or other staff. Under the FMLA, the employee's direct supervisor may not contact you.*
- **Verify leave needs.** In certain situations, an employer may provide you with a record of the employee's absences from work and ask you if your patient's needs for leave or care are consistent with the leave taken.

Protecting Your Patient's Privacy

- When an employer requires a certification, the certification does not need to provide the patient's diagnosis but does need to state appropriate medical facts that indicate the employee needs leave due to an FMLA-protected health condition.
- The FMLA **does not require employees to sign a release of their medical information**. It is an employee's choice whether to sign a release of medical information or authorization, or waiver allowing the employer to communicate directly with you.
- Under the FMLA, you only need to provide information about your patient's health as it relates to their or their family member's need for leave from work.
- Some **state or local laws may prohibit disclosure of private medical information** about your patient's serious health condition, such as providing a diagnosis and/or course of treatment.
- **Do not** include any information about genetic tests, genetic services, or the manifestation of disease or disorder in the employee's family members.

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UNITED STATES DEPARTMENT OF LABOR

What a Certification Must Include

FMLA Certification	
If your patient is seeking FMLA leave, a **complete and sufficient certification** includes:	If your patient's family member is seeking FMLA leave, a **complete and sufficient certification** includes:
• Contact information of the health care provider, including name, address, telephone number, fax number, and type of medical practice/specialty; • When the serious health condition began and how long it is expected to last; • Whether the employee is unable to work (unable to perform one or more essential job functions); • If unable to work, for how long; • A description of appropriate medical facts regarding the serious health condition;	• Contact information of the health care provider, including name, address, telephone number, fax number, and type of medical practice/specialty; • When the serious health condition began and how long it is expected to last; • A description of appropriate medical facts regarding the serious health condition; • Whether the family member needs care; • An estimate of the frequency and duration of the leave required to care for the family member;
AND If the employee's need for leave is **intermittent** or on a reduced leave schedule:	
• An estimate of how much time the employee will need for each absence, • How often the employee will be absent, and • Information establishing the medical necessity for taking such intermittent or reduced schedule leave.	

You also may, but are not required to, provide other appropriate medical facts, including diagnosis, symptoms, or any regimen of continuing treatment such as the use of specialized equipment.

As a health care provider, you are expected to provide only your best-informed medical judgment when *estimating* your patient's need for leave or care if the need is unpredictable. The FMLA does not require that you provide an exact schedule of your patient's health care needs when you are providing such an estimate.

How to Provide a Certification

- A certification may be provided in any format, such as on your letterhead, as long as it contains all the required information.
- The U.S. Department of Labor also has free, optional-use forms that may be used to certify an employee's own serious health condition or an employee's family member's serious health condition. These forms, including instructions, can be found here along with more information on using the forms.
- You should provide the medical certification or information to the patient (the employee or the employee's family member). The employee provides the medical certification or information to the employer.
- The employee or employee's family may also authorize you to provide the certification directly to the employer.
- ***Do not* send certifications or forms to the U.S. Department of Labor.**

When a Certification Must be Provided

When the employer requires a medical certification, the employee is responsible for providing a complete and sufficient certification or recertification, generally within 15 calendar days after the employer's request.

Who Pays the Cost of a Certification?

The employee is responsible for paying the cost of the certification or recertification. The employer is responsible for paying for the second and third opinions, including any reasonable travel expenses for the employee or family member.