Family and Medical Leave Act
Employee Serious Health Condition
Certification of Health Care Provider

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 due to a serious health condition to submit a medical certification issued by the employee’s health care provider. Employers must generally maintain records and documents relating to 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.

A job description has been provided to the employee and must be attached to this certification.

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your 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 due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: ____________________________________________________________
First Middle Last

SECTION III: 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.

Provider’s name and business address: ____________________________________________________________

Type of practice / Medical specialty: ____________________________________________________________

Telephone: (__________) Fax: (__________)

EMORY UNIVERSITY
Human Resources - Employee Relations
1599 Clifton Road, Suite 3.423
Atlanta, Georgia 30322

HIPAA Compliant Fax Number
404-712-5259
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. Use the information provided by the employer in Section I to answer this question.  If the employer fails to
   provide a list of the employee’s essential functions or a job description, answer these questions based upon
   the employee’s own description of his/her job functions.

   Is the employee unable to perform any of his/her job functions due to the condition:  ____ No ____ Yes.

   If so, identify the job functions the employee is unable to perform:

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:

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: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.
Upon completion, please fax this certification and job description provided by employee to:

404-712-5259
(Fax Number is HIPAA compliant)