Family and Medical Leave Act
Family Member 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 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. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees’ family members, 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.

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

HIPAA Compliant Fax Number
404-712-5259

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. 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. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name:

Name of family member for whom you will provide care:

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. Page 3 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:____________________________________________________________

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

   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. 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 and the time required for each appointment, including any recovery period:

   Explain the care needed by the patient, and why such care is medically necessary: ________________________

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:  ______________________

   _________________________________________________________________

   _________________________________________________________________

   _________________________________________________________________

   ADDITIONAL INFORMATION:  IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

   _________________________________________________________________

   _________________________________________________________________

   _________________________________________________________________

   _________________________________________________________________

   _________________________________________________________________

   _________________________________________________________________

   _________________________________________________________________

   _________________________________________________________________

   Signature of Health Care Provider  Date

   Upon completion, please fax this certification to:

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