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 5.408
Atlanta, Georgia 30322

HIPAA Compliant Fax Number
404-712-5205

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: ____________________________
First          Middle          Last

Name of family member for whom you will provide care: ____________________________
First          Middle          Last

Relationship of family member to you: ____________________________
First          Middle          Last

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:

404-712-5205
(Fax Number is HIPAA compliant)