



**CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS HEALTH CONDITION (FAMILY AND MEDICAL LEAVE ACT)**

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**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?

Yes  No If yes, provide 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?  Yes  No

Was medication, other than over-the-counter medication, prescribed?  Yes  No

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?  
 Yes  No If yes, state the nature of such treatments and expected durations of treatment:

2. Is the medical condition pregnancy?  Yes  No If yes, 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?  Yes  No

If yes, 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?  Yes  No

If yes, 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?  Yes  No

If yes, are the treatments or the reduced number of hours of work medically necessary?  Yes  No

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?  Yes  No

Is it medically necessary for the employee to be absent from work during the flare-ups?  Yes  No

If yes, 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:**

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\_\_\_\_\_  
Signature of Health Care Provider

\_\_\_\_\_  
Date