Certification of Health Care Provider for Family Member's Serious Health Condition (Family and Medical Leave Act)

Adapted from Form WH-380-F Revised May 2015
Expires 8/31/2021

Section I: For Completion by the EMPLOYER

Employer Name and Contact: _____
_____
_____

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 due to care for a 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. 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:

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 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. Do not provide information about genetic tests, as defined in 29 C.F.R.§1635.3(f), genetic services, or as defined in 29 C.F.R. §1635.3(e). 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: ( )

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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?

   ❑ Yes ❑ No If yes, provide dates of admission:

   Date(s) you treated the patient for condition:

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

   Will the patient need to have treatment visits at least twice per year due to the condition? ❑ 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. 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? ❑ Yes ❑ No

   Estimate the beginning and ending dates for the period of incapacity:

   During this time, will the patient need care: ❑ Yes ❑ No

   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? ❑ 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:

   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?

   ❑ Yes ❑ No

   Estimate the hours the patient needs care on an intermittent basis, if any:

   _____ hours 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? ❑ Yes ❑ No

   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? ❑ Yes ❑ No

   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**