

**Family and Medical Leave Act  
 CERTIFICATION OF HEALTH CARE PROVIDER FOR  
 FAMILY MEMBER'S SERIOUS HEALTH CONDITION**

**SECTION I: For Completion by the EMPLOYEE**

Please complete this section before giving this form to your family member or his/her medical provider.

Employee's name:	
Name of family member for whom employee will provide care:	
Relationship of family member to employee:	
If family member is employee's son or daughter, date of birth:	
Describe care that will be provided to family member by employee and estimate leave needed to provide care:	
Employee Signature	Date

**SECTION II: For Completion by the HEALTH CARE PROVIDER**

**PART A: MEDICAL FACTS**

1.
  - a. Approximate date condition commenced:
  - b. Probable duration of condition:
  - c. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?  
 No  Yes  
 If so, date(s) of admission: \_\_\_\_\_ date(s) of discharge: \_\_\_\_\_
  - d. Date(s) you treated the patient for condition:
  - e. Will the patient need to have treatment visits at least twice per year due to the condition?  No  Yes
  - f. Was medication, other than over-the-counter medication, prescribed?  No  Yes
  - g. 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. 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):

**PART B: AMOUNT OF CARE NEEDED**

When answering these questions, keep in mind that your patient's need or care by the employee seeking leave may include assistance with basic medical, hygiene, nutritional, safety or transportation needs, or the provision of physical or psychological care.

3. a. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery?  No  Yes

If so, estimate the beginning and ending dates for the period of incapacity:

- b. During this time, will the patient need care?  No  Yes

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

4. a. 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:

- b. Explain the care needed by the patient, and why such care is medically necessary:

5. a. 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 \_\_\_\_\_

- b. Explain the care needed by the patient, and why such care is medically necessary:

6. a. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities?  No  Yes

- b. 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 \_\_\_\_\_ days(s) per episode

c. 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

\_\_\_\_\_  
Type of Practice

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Address

\_\_\_\_\_  
Date

\_\_\_\_\_  
City, State, Zip Code