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

U.S. Department of Labor
Wage Hour Division

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR.
RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 6/30/2023

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave to care for a family member with a serious health condition to submit a medical certification issued by the family member's health care provider. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308**.

Additional (l)-1 TJ0.006 Tc -0.003 Tw -10.446 -1.157 Td(a)4.2 (ppl)6.9 (i)6.8 (e)4.2 (s)9.5 (,)3 (a)4.2 (n)12 (d i)6.8 (n)12.1 (a)4.3 (c)4.2 (c)4.
oyee when the employee was a child. An employee may also take FMLA
has assumed the obligations of a parent. No legal or biological relationship

Employee Name: _____

(3) Briefly describe the care you will provide to your family member: *(Check all that apply)*

Assistance with basic medical, hygienic, nutritional, or safety needs Transportation

Physical Care Psychological Comfort Other: _____

(4) Give your **best estimate** of the amount of leave needed to provide the care described: _____

_____

(5) If a **reduced work schedule** is necessary to provide the care described, give your **best estimate** of the reduced schedule you are able to work. From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*, I am able to work _____ (*hours per day*) _____ (*days per week).*

Employee
Signat(Si)63 (C)0 1 Tf0.001 Tw 10Tm(E)-291 (r)-409needed to pr

_____

_____

_____

Employee Name: _____

(9) Due to the condition, the patient (was / will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date: _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the period of incapacity.

(10) Due to the condition it, (was / is / will be) medically necessary for the employee to be absent from work to provide care for the patient on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur _____ times per (day / week / month) and are likely to last approximately _____ (hours / days) per episode.

Signature of
Health Care Provider _____ **Date** _____ *(mm/dd/yyyy)*

Definitions
_____
_____
_____
_____
_____