



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

Purpose of Form: The employee named below has requested a leave of absence to care for a family member with a health condition which may qualify as a protected leave under the FMLA. This medical certification form will provide Time and Labor Administration with information needed to determine if the employee's requested leave is for a qualifying reason under the FMLA.

This form should be returned within fifteen (15) calendar days of the request for this information. If additional time is needed to complete and return the form, please contact the Office of Human Resources at (850) 599-3611 to speak with a representative in Time & Labor Administration. You will need to provide a reason for the delay and the date when the certification will be provided. You may return the form in person, by mail, or by fax. The fax number is (850) 412-5566. If sending by fax, please include a fax cover sheet marked "CONFIDENTIAL" and address the fax to Time & Labor Administration.

Instructions to Employee: Please complete and sign Section I before giving this form to your family member or his/her health care provider. You are required to submit a timely, complete, and sufficient medical certification to support your request for FMLA leave due to your family member's serious health condition. This form is required to obtain or retain the benefit of FMLA protections for your leave. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request.

SECTION I – EMPLOYEE INFORMATION

Employee's Name:

Name of family member for whom you will provide care:

Relationship of family member to you:

If family member is your child, date of birth:

If the child is 18 years of age or older, is the child incapable of self-care because of a mental or physical disability? Yes No

Describe the care you will provide to your family member and estimate the leave needed to provide care:

Are you requesting leave on an intermittent or reduced schedule basis? Yes No

PART A: EMPLOYEE CERTIFICATION

I certify that the information that I provided above is true and correct.

Signature of Employee:

Date:

SECTION II - HEALTH CARE PROVIDER INFORMATION

Instructions to the Health Care Provider: The employee listed above has requested leave under the FMLA to care for your patient. Please answer, fully and completely, all applicable parts. 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 "indefinite," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave.

Provider's Name: _____

Business Address: _____

Type of Practice/Medical Specialty: _____

Phone: _____

Fax: _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition:

From: _____ To: _____

2. On page 5, describes what is meant by a "serious health condition" under the FMLA. Does the patient's condition qualify under any of the categories described? Yes No

If yes, which type of serious health condition listed on page 5 applies: 1 2 3 4 5 6

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

Yes No

If yes, dates of admission: _____

Date(s) you treated 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 duration of treatment:

3. Is the medical condition pregnancy? Yes No If yes, expected delivery date: _____

4. Describe other relevant medical facts, if any, related to the condition for which the patient 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 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:

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

If yes, estimate the start and end dates for the period of incapacity:

Start: _____ End: _____

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

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

2. 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:

Date: _____ Amt. of Time: _____ Date: _____ Amt. of Time: _____

Date: _____ Amt. of Time: _____ Date: _____ Amt. of Time: _____

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

3. 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:

Hour(s) per day: _____ # Days per week: _____ From: _____ To: _____

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

4. 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:

Serious Health Conditions

A “serious health condition” means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. **Inpatient Care**

Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. **Incapacity of More Than 3 Consecutive Days and Continuing Treatment by a Health Care Provider**

A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

- (a) **Treatment two or more times** by a health care provider, by a nurse or physician’s assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; OR
- (b) **Treatment** by a health care provider on **at least one occasion** which results in a **regimen of continuing treatment** under the supervision of the health care provider (e.g., a course of prescription medication, or therapy requiring special equipment, to resolve or alleviate the health condition). Note: This does not include taking over-the-counter medications or activities that can be initiated without a visit to a health care provider (e.g., bed rest, exercise, drinking fluids).

3. **Pregnancy**

A period of incapacity due to pregnancy, childbirth, or related medical conditions. This includes severe morning sickness and prenatal care.

4. **Chronic Conditions Requiring Treatment**

A chronic condition which:

- (a) Requires periodic visits for treatment by a health care provider, or by a nurse or physician’s assistant under direct supervision of a health care provider;
- (b) Continues over an extended period of time (including recurring episodes of a single underlying condition); and
- (c) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

5. **Permanent/Long-Term Conditions Requiring Supervision**

A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer’s, a severe stroke, or the terminal stages of a disease.

6. **Multiple Treatments (Non-Chronic Conditions)**

Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.) severe arthritis (physical therapy), kidney disease (dialysis).