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

CUNY School of Law

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee’s health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files.

Employer name and contact: CUNY School of Law – Sondra Brereton (718) 340-4543

Employee’s job title___________________________ Regular work schedule: _______________________________________

Employee’s essential job functions: __________________________________________________________________________
_______________________________________________________________________________________________________

Check if job description is attached: _____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your 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 your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. Your employer must give you at least 15 calendar days to return this form.

Your name: ________________________________________________________________________________________
First       Middle       Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. 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 “lifetime,” “unknown,” or “indeterminate” may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider’s name and business address: ______________________________________________________________

Type of practice / Medical specialty: _______________________________________________________________

Telephone: (______)________________________________ Fax: (______)_________________________________
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?
___No ___Yes. If so, 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? ___No ___Yes.

Was medication, other than over-the-counter medication, prescribed? ___No ___Yes

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. Is the medical condition pregnancy? ___No ___Yes. If so, 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: ____ No ____ Yes.

If so, 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):
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
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? ___No ___Yes.

If so, 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? ___No ___Yes.

If so, are the treatments or the reduced number of hours of work medically necessary? ___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:

___________________________________________________________________________________________

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? ___No ___Yes

Is it medically necessary for the employee to be absent from work during the flare-ups? ___No ___Yes. If so, 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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3/2009
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THE CITY UNIVERSITY OF NEW YORK
CUNY School of Law

________________________________________  _________________________________________
Signature of Health Care Provider            Date