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

THE CITY UNIVERSITY OF NEW YORK

CUNY Law School

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 to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. 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' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files.

Employer contact: Sondra Brereton (718) 340-4543

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 to care for a covered 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. 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

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:________________

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______________________________ ______________________________
Employee Signature Date

3/2009

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 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 patient needs. 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: ____

   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

   Will the patient need to have treatment visits at least twice per year due to the condition? ___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:

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2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date:______________________________

3. Describe other relevant medical facts, if any, related to the condition for which the patients needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment, such as the use of specialized equipment):

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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 employee be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No ___Yes.

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

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

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5. 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:

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

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   __________hour(s) per day; __________days per week from ________________through__________________

6. 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__________________

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

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7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ___No ___Yes

   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? ___No ___Yes

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

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ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

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Signature of Health Care Provider **Date**