



**CERTIFICATION OF HEALTH CARE PROVIDER FOR FAMILY MEMBER'S SERIOUS HEALTH  
CONDITION (FAMILY AND MEDICAL LEAVE ACT)**

**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 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 leave. Page 3 provides space for additional information, should you need it. **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?

Yes  No If yes, provide dates of admission: \_\_\_\_\_

Date(s) you treated the 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 durations of treatment:  
\_\_\_\_\_  
\_\_\_\_\_

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

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CERTIFICATION OF HEALTH CARE PROVIDER FOR FAMILY MEMBER'S SERIOUS HEALTH  
CONDITION (FAMILY AND MEDICAL LEAVE ACT)**

---

**Part B: AMOUNT OF LEAVE 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 patient be incapacitated for a single continuous period of time, including any time for treatment and recovery?  Yes  No

If yes, estimate the beginning and ending dates for the period of incapacity: \_\_\_\_\_

\_\_\_\_\_

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

If yes, explain the care needed by the patient and why such care is medically necessary:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

5. 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: \_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

6. 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:

\_\_\_\_\_ hours per day; \_\_\_\_\_ days per week from \_\_\_\_\_ through \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

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

**CERTIFICATION OF HEALTH CARE PROVIDER FOR FAMILY MEMBER'S SERIOUS HEALTH  
CONDITION (FAMILY AND MEDICAL LEAVE ACT)**

---

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**

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years, 29 U.S.C. § 2616, 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**