Montgomery County Government

Certification of Health Care Provider for Family Member's Serious Health Condition
(Family and Medical Leave Act of 1993 as amended)

SECTION I: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section I before giving this form to your family member or his/her medical provider. The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave to care for a covered family member with a serious health condition to submit a timely, and complete certification providing sufficient facts to support the request for leave. Your response is required to obtain or retain the benefit of FMLA-protected leave. Failure to do so may result in a denial of your FMLA request. You have 15 calendar days to return this form to your supervisor.

Your name: _____
First Middle Last

Your department/division _____

Your job title: _____ Your regular work schedule: _____

Your supervisor: _____

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:

_____

_____

_____

_____ _____
Employee Signature Date

SECTION II: 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 leave. Page 4 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 so, 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 duration 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 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:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___Yes ___No.

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

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

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:

_____ hour(s) 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.

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