Montgomery County Government
Medical Certification of Health Care Provider for
Employee’s Serious Health Condition Form
(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 medical provider. The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave for the employee’s 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: ________________________________    

Your essential job functions: _____________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

Check if job description is attached: _____

SECTION II: 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. 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 :(_________) _______________________

P – 1-1
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?
___Yes ___No. If yes, 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? ___Yes ___No.

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

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical
therapist)? ____Yes ___No. If so, 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. Use the information provided in Section I to answer this question.

Is the employee unable to perform any of his/her job functions due to the condition: ____ Yes ____ No.

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? ____Yes ____No.

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? ____Yes ____No.

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

_________________________________________________________________________________

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? ____Yes ____No.

Is it medically necessary for the employee to be absent from work during the flare-ups? ____Yes ____No. If yes, 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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_______________________________________ ______________________________________
Signature of Health Care Provider   Date