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

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

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_____________________________________________________________________________________

Signature of Health Care Provider ___________________________ Date ___________________________