Family Medical Leave

Certification of Health Care Provider for Family Member's Serious Health Condition

Instructions to the Employee: Please complete the following information before giving this form to your family member's medical provider.

Employee's Name: _____
First Middle Last

Name of family member for who 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**

Instructions to the Health Care Provider: The employee listed above has requested leave under the Family Medical Leave Act (FMLA) to care for your patient. 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 needs leave to care for his/her family member. ***Please be sure to sign this form on the last page.***

Provider's Name and Business Address: _____

Type of Practice/Medical Specialty: _____

Telephone: (___) _____ Fax: (___) _____

Part A: Medical Facts

1. Diagnosis (describe relevant medical facts such as symptoms, diagnosis, or any regimen of continuing treatment):
   _____
   _____
   _____

   Approximate date condition commenced: _____

   Probable duration of condition: _____

   Probable duration of the patient's present incapacity (if different): _____

   Was 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 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: _____
_____

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

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, hygiene, nutritional, safety, transportation needs, or the provision of physical psychological care.*

3. Will the patient 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: _____

During this time, will the patient need care? ___No ___Yes

Explain the care the patient needs and why such care is medically necessary: _____
_____
_____
_____

4. 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:
_____
_____

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

5. 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: _____
_____
_____

6. 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: _____
   _____
   _____

7. Estimate the period of time care is needed or the employee's presence would be beneficial: _____
   _____

8. After reviewing the employee's signed statement on page 1:

   Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety, or transportation? ___No___Yes

   Is the employee's presence necessary or would it be beneficial for the care of the patient? This may include psychological comfort. ___No ___Yes

_____ **_____**

Signature of Health Care Provider **Date**

Return Completed Form to: **Lamar University/Lamar Institute of Technology Human Resources Office**
PO Box 11127 Beaumont, TX 77710 or Fax to (409) 880-8464