

Office of Human Resources Appalachian State University

Type: Intermittent or Continuous

DOH: \_\_\_/\_\_\_/\_\_\_

FML BEG: \_\_\_/\_\_\_/\_\_\_

FML END: \_\_\_/\_\_\_/\_\_\_

END REASON: \_\_\_\_\_

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



**SECTION I: For Completion by the EMPLOYER / SUPERVISOR**

**INSTRUCTIONS:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, re-certifications, or medical histories of employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Supervisor name and contact information (Print) \_\_\_\_\_

**SECTION II: For Completion by the EMPLOYEE**

**INSTRUCTIONS:** Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: \_\_\_\_\_ Banner: \_\_\_\_\_  
First Middle Last

**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 dates** needed to provide care:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Employee signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Employee Name: \_\_\_\_\_ Family Member: \_\_\_\_\_

**SECTION III: For Completion by the HEALTH CARE PROVIDER**

**INSTRUCTIONS:** 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. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). 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? \_\_\_ No \_\_\_ Yes.  
If so, dates of admission: \_\_\_\_\_

Date(s) you treated the patient for condition: \_\_\_\_\_

Was medication, other than over-the-counter medication, prescribed? \_\_\_ No \_\_\_ Yes.

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 yes, state the nature of such treatments and expected duration of treatment: \_\_\_\_\_

**2.** Is the medical condition pregnancy? \_\_\_ No \_\_\_ Yes. If so, expected delivery date: \_\_\_\_\_

**3.** 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):

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

Employee Name: \_\_\_\_\_ Family Member: \_\_\_\_\_

**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 due to his/her medical condition 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 needed by the patient and why such care is medically necessary:

5. 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 recover period:

Explain the care needed by the patient during treatment schedule 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? \_\_\_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 on this intermittent basis and why such care is medically necessary:

7. Will the condition cause episodic flare-ups periodically preventing the patient from performing 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

\_\_\_\_\_  
**Signature of Health Care Provider**

\_\_\_\_\_  
**Date**

**Employee PLEASE RETURN COMPLETED FORM TO:**

Carolyn Bosley

Leave Management Administrator

Appalachian State University

ASU Box 32010

Boone, NC 28608

Phone: (828) 262-6488

Fax: (828) 262-6489

**For Completion by Appalachian State University Human Resource**

FML \_\_\_YES \_\_\_NO

Approved by: \_\_\_\_\_ Designation Letter \_\_\_\_/\_\_\_\_/\_\_\_\_