

SECTION II: For Completion by the HEALTHCARE PROVIDER

INSTRUCTIONS to the HEALTHCARE 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. 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 four (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?
___ 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 healthcare 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:

Is the medical condition pregnancy? ___ No ___ Yes. If so, expected delivery date: _____

Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment). Please Note: If this form is being used to certify the need for leave under the California Family Rights Act, California regulations prohibit the disclosure of the underlying diagnosis of the serious health condition involved without the consent of the patient.

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.

For Continuous FML Requests

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___ No ___ Yes.

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

With the understanding that **this FML request is for the employee and not the patient**, please estimate the beginning and ending dates of the **time the employee will need off** to assist during the patient's period of incapacity: _____
(mm/dd/yyyy - mm/dd/yyyy)

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

For Intermittent FML Requests

5. Will the patient require follow-up treatment, 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:

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 _____
(mm/dd/yyyy) (mm/dd/yyyy)

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? ___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 **or** 1 YEAR (circle one)

Episodes of incapacity are estimated to occur (e.g., 1 time per month, 6 hours per episode):

Frequency: _____ times per _____ week(s) **or** _____ 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:

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Signature of Health Care Provider

Date

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