

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

Route this form to: Supervisor/responsible administrator	U Wide Form: UM 1701 Rev: Mar 2009
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NOTE: Failure to fully complete this form could result in an initial denial of an FMLA leave or a delay in approval of an FMLA leave for the employee. The information sought relates only to the family member's condition for which the employee is taking FMLA leave. Where the need for leave is foreseeable, an employee provides at least 30 days advance notice of the need for leave to the supervisor/responsible administrator whenever possible.

SECTION I: For Completion by the SUPERVISOR/RESPONSIBLE ADMINISTRATOR

INSTRUCTIONS: This certification form is to be used when an employee is seeking FMLA leave due to the serious health condition of a family member. Please complete Section I before giving this form to the employee.

Employer name including department/unit:	
Employee's job title:	Employee's regular work schedule:

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS: Please complete Section II fully and completely before giving this form to your family member or his/her health care provider. While you are not required to provide this information, failure to do so may result in a denial of your request for FMLA leave. By signing this form, you represent that the information you provided is true and accurate. Unless advised otherwise in writing, you have 15 calendar days to return this form to the supervisor/responsible administrator.

Name of family member for whom you will provide care (first, middle, and last name):	
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 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. Page 4 provides space for additional information, should you need it. Please be sure to sign the form on the page 4.

Provider's name and business address:	
Type of practice/Medical specialty:	
Telephone (with area code):	Fax (with area code):

PART A – MEDICAL FACTS

Approximate date condition commenced:
Probable duration of condition:

Was the patient admitted for an overnight stay in the hospital, hospice, or residential medical care facility?

No: <input type="checkbox"/>	Yes: <input type="checkbox"/>	If yes, dates of admission:
Date(s) you treated the patient for condition:		

Was medication, other than over-the-counter medication, prescribed?

No: <input type="checkbox"/>	Yes: <input type="checkbox"/>
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Will the patient need to have treatment visits at least twice per year due to the condition?

No: <input type="checkbox"/>	Yes: <input type="checkbox"/>
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Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

No: <input type="checkbox"/>	Yes: <input type="checkbox"/>	If yes, state the nature of such treatments and expected duration of treatment:
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Is the medical condition pregnancy?

No: <input type="checkbox"/>	Yes: <input type="checkbox"/>	If yes, expected delivery date:
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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):

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:

Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery?

No: <input type="checkbox"/>	Yes: <input type="checkbox"/>	If yes, estimate the beginning and ending dates for the period of incapacity:
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During this time, will the patient need care?

No: <input type="checkbox"/>	Yes: <input type="checkbox"/>
If yes, explain the care needed by the patient and why such care is medically necessary:	

Will the patient require follow-up treatments, including any time for recovery?

No: <input type="checkbox"/>	Yes: <input type="checkbox"/>
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:	

Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?

No: <input type="checkbox"/>	Yes: <input type="checkbox"/>
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Estimate the hours the patient needs care on an intermittent basis, if any:

Hour(s) per day:	How many days per week:	From (start date):	Through (end date):
Explain the care needed by the patient and why such care is medically necessary:			

Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities?

No: <input type="checkbox"/>	Yes: <input type="checkbox"/>
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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	

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 Authorized Health Care Provider:	Date signed:
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FMLA: Notice to Employees of Rights under FMLA

Route this form to:	U Wide Form UM1699
Employee	Rev: Mar 2009

EMPLOYEE RIGHTS AND RESPONSIBILITIES**Basic Leave Entitlement**

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer. For additional information go to: www.wagehour.dol.gov.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.