**WEST VIRGINIA MILITARY AUTHORITY**
**FEDERAL FAMILY and MEDICAL LEAVE ACT (FMLA)**

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

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

**INSTRUCTIONS to the EMPLOYER:** The federal Family and Medical Leave Act (FMLA) provide 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. 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, recertifications, 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.

Employer name and contact: _____

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

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II before giving this form to your family member or his or her medical provider. The FMLA permit an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for 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. Failure to provide a complete and sufficient medical certification may result in a denial of your leave request. Your employer must give you at least 15 calendar days to return this form to your employer.

Your name: _____

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 needed to provide care:

_____

_____

_____

_____

_____ _____

Employee Signature Date

## SECTION III: 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 (required):_____

   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 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: _____

3. 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:

4. 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:

   FROM: _____ TO: _____ (required)

   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 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 _____

   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 (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:

   _____
   _____
   _____
   _____
   _____

ADDITIONAL INFORMATION (Identify question number with your additional answer):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____ _____

Signature of Health Care Provider Date