Certification of Health Care Provider for Employee’s Serious Health Condition
(Family and Medical Leave Act)

Employer contact: Lenora Salts  FAX # (402) 280-3113

FOR COMPLETION BY EMPLOYEE BEFORE GIVING FORM TO HEALTH CARE PROVIDER:

Employee Name: ____________________________________________

Regular work schedule: ________________________________________

Essential job functions: _________________________________________

FOR COMPLETION BY HEALTH CARE PROVIDER
INSTRUCTIONS TO THE HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Please 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 is seeking leave. Please be sure to sign the form on the last page.

PART A: MEDICAL FACTS

1. Approximate date condition commenced: ____________________________

Probable duration of condition: _______________________________________

2. Describe 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):

____________________________________________________________________

____________________________________________________________________

Mark below as applicable:

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

No____ Yes____ If yes, 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 medication, other than over-the-counter medication, prescribed? 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 yes, expected delivery date: ____________________________
3. Use the information provided by the employee to answer this question.

Is the employee able to perform any of his/her essential job functions due to the condition: No _____ Yes _____

If no, identify the job functions the employee is unable to perform:

PART B: AMOUNT OF LEAVE NEEDED (Please choose applicable option):

1. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? No _____ Yes _____

   If yes, estimate the beginning and ending dates for the period of incapacity: ______________________________

   OR

2. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee’s medical condition? No _____ Yes _____

   If so, are the treatments or the reduced number of hours of work medically necessary? 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:

   ________________________________________________________________

   OR

   Estimate the part-time or reduced work schedule the employee needs, if any:

   __________ hour(s) per day; __________ days per week from __________ through __________

   OR

3. Will the condition cause episodic or intermittent flare-ups periodically preventing the employee from performing his/her job functions? No _____ Yes _____

   Is it medically necessary for the employee to be absent from work during the flare-ups? No _____ Yes _____

   If so, explain:

   ________________________________________________________________

   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

Provider’s name and business address: ________________________________ Type of practice ________________________________

Medical specialty: ________________________________

Telephone: (_______) __________________ Fax: (_______) __________________