Certification of Health Care Provider for
Employee's Serious Health Condition
under the Family and Medical Leave Act

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DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR .
RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 6/30/2023

at least
15 calendar days to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I – EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F § 825.306. You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Additionally, you may not request a certification for FML.002 Tc 0.02 Tw 3.9 (y n) First Last

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Employee Name: ____

(4) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. (e.g, use of nebulizer, dialysis) ____

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PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. 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.

(5) Due to the condition, the patient † (had / † will have) planned medical treatment(s) (scheduled medical visits) (e.g. psychotherapy, prenatal appointments) on the following date(s): ____

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(6) Due to the condition, the patient † (was / † will be) referred to other health care provider(s) for evaluation or treatment(s).

State the nature of such treatments: (e.g. cardiologist, physical therapy) ____

Provide your best estimate of the beginning date _____________ (mm/dd/yyyy) and end date _____________ (mm/dd/yyyy) for the treatment(s).

Provide your best estimate of the duration of the treatment(s), including any period(s) of recovery (e.g. 3 days/week)

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(7) Due to the condition, it is medically necessary for the employee to work a reduced schedule.

Provide your best estimate of the reduced schedule the employee is able to work. From _________________ (mm/dd/yyyy) to _________________ (mm/dd/yyyy), the employee is able to work: (e.g., 5 hours/day, up to 25 hours a week)

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(8) Due to the condition, the patient † (was / † will be) incapacitated for a continuous period of time, including any time for treatment(s) and/or recovery.

Provide your best estimate of the beginning date___________________ (mm/dd/yyyy) and end date __________iTm (________)Tj -0.011 Tc ()10.___d [(__)-1n3.8 Tm [(()9 (m)-2 /ExtraCh5 363.29 2693.8 Tm [(()9 (