**FMLA Certification of Health Care Provider Form**

*Completed by a licensed medical provider to verify the need for FMLA leave.*

**Section 1: Employee Information**

|  |  |  |  |
| --- | --- | --- | --- |
| **Employee Name:** |  | **Employee ID (if applicable):** |  |
| **Job Title:** |  | **Department:** |  |
| **Employer Name:** |  | **Work Address:** |  |
| **Phone Number:** |  | **Request Type:** | ☐ New FMLA Request ☐ Continued Leave ☐ Intermittent Leave |

**Section 2: Patient Information**

*To be completed by the health care provider.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Name:** |  | | |
| **Date of Birth:** |  | **Relationship to Employee:** | ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other: |

**Section 3: Medical Facts**

*The employee has requested leave under the Family and Medical Leave Act (FMLA). Please provide essential medical facts related to the condition.*

1. **Medical condition requiring leave:**

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| --- | --- | --- | --- |
| **Date condition began:** |  | **Probable duration of condition:** |  |
| **Was the patient admitted for inpatient care?** | ☐ Yes ☐ No | If yes, provide dates: | |
| **Is the condition chronic or long-term?** | ☐ Yes ☐ No | If yes, explain management needs: | |

**Describe relevant medical facts (symptoms, diagnosis, treatment):**

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**Section 4: Need for Leave**

1. **Is the patient unable to work or perform essential job functions?** ☐ Yes ☐ No
   * If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Is continuous leave required?** ☐ Yes ☐ No
   * Estimated dates: From \_\_\_\_\_\_\_\_\_\_\_ To \_\_\_\_\_\_\_\_\_\_\_
3. **Is intermittent or reduced leave schedule needed?** ☐ Yes ☐ No
   * Frequency (times per week/month): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   * Duration of each episode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. **Is follow-up treatment required?** ☐ Yes ☐ No
   * Provide expected schedule: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 5: Care for Family Member (If Applicable)**

1. **Does the employee need to care for the patient?** ☐ Yes ☐ No
2. **Explain why patient requires employee’s care:**
3. **Estimated time the employee will be needed:**
   * From \_\_\_\_\_\_\_\_\_\_\_\_\_ To \_\_\_\_\_\_\_\_\_\_\_\_\_
   * Hours per day/week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 6: Health Care Provider Information**

|  |  |  |  |
| --- | --- | --- | --- |
| **Provider Name:** |  | | |
| **Specialty:** |  | **Facility/Practice Name:** |  |
| **Address:** |  | **Phone:** |  |
| **Fax:** |  | **Email:** |  |

**I certify that the information provided is true and correct to the best of my knowledge.**

**Signature of Health Care Provider:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 7: Employer Use Only**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date Received:** |  | **FMLA Eligibility Confirmed:** | ☐ Yes ☐ No |
| **Additional Notes:** |  |  |  |

\*This form is used to determine eligibility for FMLA leave under federal law. All medical information will be kept confidential.