

**CERTIFICATION OF HEALTH CARE PROVIDER FOR FAMILY MEMBER'S SERIOUS HEALTH
CONDITION (FAMILY AND MEDICAL LEAVE ACT)**

Part A: Medical Facts

1. Approximate date condition commenced: _____
Probable duration of condition: _____
Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
 Yes No If yes, provide dates of admission: _____
Date(s) you treated the patient for condition: _____
Was medication, other than over-the-counter medication, prescribed? Yes No
Will the patient need to have treatment visits at least twice per year due to the condition? Yes No
Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
 Yes No If yes, state the nature of such treatments and expected durations of treatment:

2. Is the medical condition pregnancy? Yes No If yes, expected delivery date: _____
3. Describe other relevant medical facts, if any related to the condition for which the patient needs care (such as 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? Yes No
Estimate the beginning and ending dates for the period of incapacity:

- During this time, will the patient need care: Yes No
Explain the care needed by the patient and why such care is medically necessary:

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5. Will the patient require follow-up treatments, including any time for recovery? Yes No

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?

Yes No

Estimate the hours the patient needs care on an intermittent basis, if any:

_____ hours 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? Yes No

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? Yes No

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

