University of Missouri

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

(Family and Medical Leave Act)

SECTION I: For Completion by EMPLOYER

Employer Name	Employer Contact Information

SECTION II: For Completion by EMPLOYEE

Please complete Section 11 before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA 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. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Employee's Name (First, Middle, Last)		Employee's EmplID
Name of Family Member to whom the you will provide care (First, Middle, Last)	Relationship of Family Member to you	Date of Birth (If employee's son or daughter)
Describe care you will provide to your family member and estimate leave needed to provide care.		

Employee's Signature _____ Date _____

SECTION III: For Completion by 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. At the end of this document is space for additional information, should you need it. **Please be sure to sign the form on the last page.**

Provider's Name	Provider's Business Address
Type of Practice/Medical Specialty	
Telephone ( )	Fax ( )

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, 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? ☐ Yes ☐ No
Was medication, other than over-the-counter medication, prescribed? ☐ 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 treatment and expected duration 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 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 due to his/her medical condition, including any time for treatment or recovery? ☐ Yes ☐ No

If yes, 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:

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

If yes, estimate the hours the patient needs care on an intermittent basis, if any:

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

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., I episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) month(s) _____ Duration: _____ hour(s) or _____ day(s) per episode

Will 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.

The Genetic Information Nondiscrimination Act of 2008 ("GINA") prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Signature of Health Care Provider

Date