



CITY OF BRYAN
The Good Life, Texas Style.

CERTIFICATION OF HEALTH CARE PROVIDER FOR FAMILY MEMBER'S SERIOUS HEALTH CONDITION

(Family and Medical Leave Act)

SECTION I: EMPLOYER

Employer Name and Contact: City of Bryan –Teresa McGinnis, HR Generalist
979-209-5063 (phone), 979-209-5059 (fax) or tmcginnis@bryantx.gov (email)

SECTION II: To be completed by the EMPLOYEE

Please complete this section before giving the form to your family member or their health care provider. Your response is required to obtain or retain the benefit of FMLA protections. Failure to provide a complete and sufficient medical certification may result in the denial of your FMLA request. Your employer must give you at least 15 calendar days to return this form.

Employee Name (First Middle Last): _____

Name of Family Member Receiving Care (First Middle Last): _____

Relationship of Family Member to You: _____

If family member is your son or daughter, date of birth: _____

Employee Signature

Date

SECTION III: To be completed by HEALTH CARE PROVIDER ONLY

Instructions to the Health Care Provider: The employee listed above has requested leave under the FMLA to care for your patient. Please answer, fully and completely, all applicable parts. Your answer should be your best estimate based upon your medical knowledge and experience. "Unknown" or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Failure to provide sufficient information may cause the employee's FMLA request to be delayed or denied. Please be sure to sign the form on the last page.

GINA Notification to the Health Care Provider: Do not provide information about genetic tests, genetic services, or the manifestation of disease or disorder in the employee's family members.

PART A: MEDICAL FACTS

Approximate date condition began: _____ Probable duration: _____

Date(s) you treated the patient for condition: _____

1. Describe medical facts such as symptoms, diagnosis, or any regimen of continuing treatment related to the condition for which the patient needs care: _____

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

No Yes If yes, dates of admission: _____

3. Will the patient need to have treatment/visits at least twice per year due to the condition? No Yes

4. Was medication, other than over-the-counter medication, prescribed? No Yes

5. 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 and expected duration of treatment: _____

6. Is the medical condition pregnancy? No Yes If yes, expected delivery date: _____



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PART B: AMOUNT OF CARE NEEDED

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.

1. Explain the care needed and why such care is medically necessary: _____

2. Will the patient be incapacitated and require care for a single continuous period of time due to their medical condition?
 No Yes If yes, beginning and ending dates: _____
3. Will the patient require care on a part-time or reduced schedule basis, or to attend follow-up treatments?
 No Yes If yes, please estimate:
_____ Hour(s) per day; _____ Day(s) per week From (date) _____ through (date) _____
4. Will the patient have episodic flare-ups preventing him/her from participating in normal daily activities and require care during this time?
 No Yes If yes, estimate the frequency and duration over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):
Frequency: _____ number of episodes every _____ week(s) or month(s)
Duration: _____ hour(s) or _____ day(s) per episode
From (date) _____ through (date) _____

ADDITIONAL INFORMATION

Provider's Name and Business Address: _____

Type of Practice / Medical Specialty: _____

Telephone: _____

Fax: _____

Signature of Health Care Provider

Date: _____