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: EMPLOYEE

Please complete this section before giving the form to your family member or his/her health care 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. 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 a 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: ______________________________

Describe Care You Will Provide to Your Family Member and Estimate Leave Needed to Provide Care:

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______________________________________ ______________________
Employee Signature **Date**

SECTION III: 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. Do not provide information about genetic tests, genetic services, or the manifestation of disease or disorder in the employee's family members. Please be sure to sign the form on the last page.

Provider's Name and Business Address: ____

Type of Practice / Medical Specialty: ____

Telephone: ________________________ **Fax**: ________________________

PART A: MEDICAL FACTS

1. Approximate date condition commenced: ____

2. Probable duration of condition: ____

3. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ☐ No ☐ Yes

   a. If so, dates of admission: ____

4. Date(s) you treated the patient for condition: ____

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

6. Was medication, other than over-the-counter medication, prescribed? ______________________________

7. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ☐ No ☐ Yes

   a. If so, state the nature of such treatments and expected duration of treatment: ________________________

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8. Is the medical condition pregnancy? ☐ No ☐ Yes

   a. If so, expected delivery date: ____

9. 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):

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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.

10. Will the patient be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ☐ No ☐ Yes

    a. If so, estimate the beginning and ending dates for the period of incapacity: __________________________

    b. During this time, will the patient need care? ☐ No ☐ Yes

    c. Explain the care needed by the patient and why such care is medically necessary:

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

    a. Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: ______________________________________

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    b. Explain the care needed by the patient, and why such care is medically necessary: ____________________

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12. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? ☐ No ☐ Yes

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

    _______ hour(s) per day; _______ days per week from ____________ through ____________

b. Explain the care needed by the patient, and why such care is medically necessary: ____________________

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13. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ☐ No ☐ Yes

a. Does the patient need care during these flare-ups? ☐ No ☐ Yes

b. Explain the care needed by the patient, and why such care is medically necessary: ____________________

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14. 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):

a. Frequency: _______ times per _______ week(s) _______ month(s)

b. Duration: _______ hours or _______ day(s) per episode

ADDITIONAL INFORMATION:

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Signature of Health Care Provider **Date**