EMORY HEALTHCARE

FMLA Certification of Health Care Provider
Employee Serious Health Condition

**** Failure to provide a completed certification within 15 calendar days may result in a denial of FMLA. Your timely response is required to obtain or retain the benefit of FMLA protections. ****

SECTION I: For Completion by the EMPLOYEE: Before giving this form to your medical provider.
Employee Name:

_____ Employee ID: _____Date: _____
First Middle Last

SECTION II: For Completion by the HEALTHCARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. 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" or "unknown" may not be sufficient to determine FMLA coverage. **Please be sure to sign the form on the second page.**

PART A - / MEDICAL FACTS:

1. Approximate date condition commenced:_____
2. Probable duration of condition: _____
3. Was the patient ***admitted*** for ***greater than 24 hours*** in a hospital, hospice, or residential medical care facility? ___No ___Yes. 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(s) prescribed? __No __Yes
7. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g. physical therapist)? ___No ___Yes If so, state the nature of treatments and expected duration of treatment:

_____

8. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____
9. Describe relevant medical facts related to the condition for which the employee seeks leave (such facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

10. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.
    Is the employee unable to perform any of his/her job functions due to the condition: ____ No ___ Yes
    If so, identify the job functions the employee is unable to perform: _____

_____

_____

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Employee's Name _____ **Employee ID:** _____

PART B – / AMOUNT OF LEAVE NEEDED

1. Will the employee be ***incapacitated for a single continuous period of time*** due to his/her medical condition, including any time for treatment and recovery? __No __Yes If yes, estimate the ***beginning and ending dates*** for the period of incapacity: _____

2. Will the employee need to attend follow-up treatment appointments or work part-time or a reduced schedule because of the employee's medical condition? __No __Yes

A. If yes, is the treatment or the reduced schedule medically necessary? __No __Yes

B. Estimate the treatment schedule, if any, including the dates of any scheduled appointments and the time required, including any recovery period: _____

_____

C. Estimate the part-time or reduced work schedule the employee needs, if any:
_____ hours per day/shift; _____ days per week from _____ through _____

3. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____No ____Yes.

Is it medically necessary for the employee to be absent from work during the flare-ups? ___ No ___Yes

If so, explain: _____

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

Additional Information: _____

_____

_____

Signature of Health Care Provider _____**Date:**_____

Print Provider's Name: _____

Business Address _____

Type of Practice / Medical Specialty: _____

Telephone: (_____) _____ **Fax: (_____)** _____

RETURN TO: Emory Healthcare Centralized Leave Office
1455 Montreal Road
Tucker, GA 30084
Telephone: (404) 251-3452
Confidential Fax: (404) 686-5942 Email: ehccentralizedleaveoffice@emoryhealthcare.org