Certification of Health Care Provider for Employee's Serious Health Condition
(Family Medical Leave Act)

The Family and Medical Leave Act (FMLA) provides that an employee seeking FMLA protection because of a need for leave due to a serious health condition submit a medical certification issued by the employee's health provider. The employee's department will maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies. Departments must send completed copies of FMLA to Human Resources.

This form asks the health care provider for the information necessary for a **complete** and **sufficient medical certification**, which is set out at 29 C.F.R. § 825.306. **You may not ask the employee to provide more information than allowed under the FMLA regulations**, 29 C.F.R. §§ 825.306-825.308. Additionally, **you may not** request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Section 1: For Completion by the Employee or Employer

Please complete Section 1 before providing this form to the health care provider. FMLA permits CSU to require the submission of a **timely, complete, and sufficient medical certification** to support a request for FMLA leave due to the employee's own serious health condition. The employer must give the employee at least **15 calendar days** to provide the certification. Failure to provide a complete and sufficient medical certification may result in a denial of the FMLA request.

Employee Name:_____ Employee ID#:_____

Employer Name: **Colorado State University** Date Certification was requested:_____ *(mm/dd/yyyy)*

Employee's Job Title:_____ Department:_____

Regular Work Schedule:_____ *(weekly work hours/days)*

Employee's Essential Job Functions:_____

(The essential functions of the employee's position are determined with reference to the position the employee held at the time the employee notified the employer of the need for leave or the leave started, whichever is earlier.)

Check if Job Description is Attached: ☐

Medical Certification form must be returned by_____ *(mm/dd/yyyy)*
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

Section 2: For Completion by the Health Care Provider

Your patient has requested leave under the FMLA. The FMLA allows an employer to require that the employee submit a timely, **complete** and **sufficient** medical certification to support a request for FMLA leave due to the serious health condition of the employee. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves *inpatient care* or *continuing treatment by a health care provider*. For more information about the definitions of a serious health condition under the FMLA, see the chart on page 3. Please provide your contact information, complete all relevant parts of this Section and sign the form.

Health Care Providers Name:_____

Provider's Business Address:_____

Type of Practice/Medical Specialty:_____

Telephone: _(____) _____ Fax: _(____) _____ Email:_____

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Employee's Name_____

Part A: Medical Information

Limit your response to the medical condition(s) for which the employee is seeking FMLA leave and answers should be your **best estimate**. After completing Part A, complete Part B to provide information about the amount of leave needed. Be as **specific** as you can**;** terms such as **"lifetime," "unknown,"** or **"indeterminate"** may not be sufficient to determine FMLA coverage.

Note: For FMLA purposes, "incapacity" means the inability to work or perform regular daily activities due to the condition, treatment of, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

(1) State the approximate date the condition started or will start: _____ *(mm/dd/yyyy)*

(2) Provide your **best estimate** of how long the condition lasted or will last: _____ *(mm/dd/yyyy)*

(3) Check the applicable box(es) for the questions below, and provide the amount of leave needed in Part B:

☐ Inpatient Care: The patient ☐ has been ☐ is expected to be admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____ *(mm/dd/yyyy)*

☐ Incapacity plus Treatment: *(e.g. outpatient surgery)* The patient ☐ has been ☐ is expected to be incapacitated for more than three consecutive, full calendar days from _____ to _____ *(mm/dd/yyyy)*

The patient ☐ was ☐ will be seen on the following date(s): _____ *(mm/dd/yyyy)*

The condition ☐ has ☐ has not also resulted in a course of continuing treatment under the supervision of a health care provider *(e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment)*

☐ Pregnancy: The condition is pregnancy. List the expected delivery date: _____ *(mm/dd/yyyy)*

☐ Chronic Conditions: *(e.g. asthma, migraines)* It is medically necessary for the patient to have treatment visits at least twice per year.

☐ Permanent or Long Term Conditions: *(e.g. Alzheimer's, terminal stages of cancer)* Incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ Conditions requiring Multiple Treatments: *(e.g. chemotherapy treatments, physical therapy)* It is medically necessary for the patient to receive multiple treatments.

☐ None of the Above: If none of the above condition(s) were checked, no additional information is needed. Please sign and date page 3.

(4) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. *(e.g., use of nebulizer, dialysis)*

_____

_____

_____

Part B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. Questions request a response as to the frequency or duration of a condition, treatment, etc. Answers should be your best estimate based upon your medical knowledge, experience, and examination of the patient.

(5) Due to the condition, the patient ☐ had ☐ will have **planned medical treatment**(**s**) (scheduled medical visits) *(e.g. psychotherapy, prenatal appointments)* on the following date(s): _____ *(mm/dd/yyyy)*

(6) Due to the condition, the patient ☐ was ☐ will be **referred to other health care provider**(**s**) for evaluation or treatment(s).

State the nature of such treatments: *(e.g. cardiologist, physical therapy)* _____

Provide your **best estimate** of the beginning _____ and end dates _____ *(mm/dd/yyyy)* for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery *(e.g. 3 days/week)*_____

_____

(7) Due to the condition, it is medically necessary for the employee to work a **reduced schedule**.

Provide your **best estimate** of the reduced schedule: *(e.g., 5 hours/day, up to 25 hours/week)* _____

From _____ to _____ *(mm/dd/yyyy)*

(8) Due to the condition, the patient ☐ was ☐ will be **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning _____ and end dates _____ *(mm/dd/yyyy)* for the period of incapacity.

(9) Due to the condition, it ☐ was ☐ is ☐ will be medically necessary for the employee to be absent from work on an **intermittent basis** (periodically), including for any episodes of incapacity *(i.e., episodic flare-ups)*. Provide your **best estimate** of the frequency and duration of the episodes of incapacity.

Over the next 6 months, episodes of incapacity are estimated to occur _____ times per ☐ day ☐ week ☐ month and are likely to last approximately _____ ☐ hours ☐ days per episode.

Part C: Essential Job Functions

If provided, the Job Description may be used to answer this question. If the employer fails to provide a statement of the employee's essential functions or a job description, answer these questions based upon the employee's own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be not able to perform the essential job functions of the position during the absence for treatment(s).

(10) Due to the condition, the employee ☐ was not able ☐ is not able ☐ will not be able) to perform one or more of the essential job function(s). Identify at least one essential job function the employee is not able to perform:

_____

_____

Additional Information

_____

_____

_____

_____ _____

Signature of Health Care Provider **Date**

Definitions of a Serious Health Condition (See 29 C.F.R. §§ 825.113-.115)
Inpatient Care
• An overnight stay in a hospital, hospice, or residential medical care facility. • Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay
Continuing Treatment by a Health Care Provider (any one or more of the following)
Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.
Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.
Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.