Certification of Health Care Provider for Family Member'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 of a family member, submit a medical certification issued by the family member's health care provider. The employer must give the employee at least 15 calendar days to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Departments must send completed copies of FMLA to Human Resources.

Section 1: For Completion by the Employer

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. This form does not apply if FMLA leave is to bond with a healthy newborn or a child placed for adoption or foster care.

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.

Employee Name:____________________________ Employee ID#:____________________________

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

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 Employee

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 serious health condition of a family member**. You are responsible for making sure the medical certification is provided to your employer within the time frame requested, which must be at least 15 calendar days**. 29 C.F.R. §§ 825.305-825.306. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA leave request. 29 C.F.R. § 825.313.

Name of the family member for whom you will provide care: ____________________________________

Select the relationship of the family member to you. The family member is your:

☐ spouse, ☐ domestic partner ☐ civil union partner ☐ parent ☐ child, under age 18
☐ child, age 18 or older and incapable of self-care because of a mental or physical disability

The terms "child" and "parent" include in loco parentis relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for an individual who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a child for whom the employee has assumed the obligations of a parent.

Briefly describe the care you will provide to your family member: *(Check all that apply)*

☐ Assistance with basic medical, hygienic, nutritional, or safety needs ☐ Transportation ☐ Physical Care ☐ Psychological Comfort
☐ Other: ________________________________

Give your best estimate of the amount of leave needed to provide the care described: ________________________

If a reduced work schedule is necessary to provide care, give your best estimate of the reduced schedule you are able to work.

From ____________ to ____________ *(mm/dd/yyyy)*, I am able to work __________ *(hours per day)* __________ *(days per week)*.

Employee Signature ____ Date ______________ *(mm/dd/yyyy)*

HUMAN RESOURCES
COLORADO STATE UNIVERSITY

555 S. Howes Street, 2nd Floor | Campus Delivery 6004
Fort Collins, CO 80523-6004
P: 970-491-6947 | hr.colostate.edu

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Employee's Name________________________________

Section 2: For Completion by the Health Care Provider

A family member of your patient has requested leave under the FMLA to care for your patient. 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:__________________________

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) Patient's Name____

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

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

(4) For FMLA to apply, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient *(e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort).*

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(5) 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.

(6) 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)*

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Employee's Name______________________________

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.

(7) 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)*

(8) 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)*______________

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(9) 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 date: ________________ and end date _____________ *(mm/dd/yyyy)* for the period of incapacity.

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

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.

Additional Information

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____ _________________________

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: ○ 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, ○ 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.