

**Certification of Health Care Provider  
(Family Medical Leave Act)**

**Part A For Completion by the Employee:** Please complete this section before giving this form to your family member's medical 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. If requested by your employer, 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 or delay of your FMLA request. You have 15 calendar days to return this form to your employer.

<b>Name:</b>	<b>Employee Number:</b>
<b>Department:</b>	<b>Title:</b>
<b>Reports to:</b>	<b>Status:</b> ___ Full-Time ___ Part-Time ___ Temporary
<b>Today's Date:</b>	<b>Hire Date:</b>
<b>Name of Family Member for whom you will provide care:</b>	<b>Relationship of family member to you:</b>
<b>If family member is your son or daughter, date of birth:</b>	
<b>Describe care you will provide to your family member and estimate leave needed to provide care:</b>	
<b>Employee Signature:</b>	<b>Date:</b>

<b>Part B For Completion by the HEALTH CARE PROVIDER:</b>	
Instructions: The employee listed above has requested leave under the FMLA to care for your patient. 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," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs care. Please be sure to sign the form on the last page.	
Provider's name and business address:	
Type of practice/Medical specialty:	
Telephone:	Fax:
<b>MEDICAL FACTS</b>	
1. Approximate date condition commenced:	Probable duration of condition:
Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility: ___ Yes ___ No	If yes, dates of admission: Date(s) you treated the patient for condition:
Will the patient need to have treatment visits at least twice a year due to the condition? ___ Yes ___ No	
Was medication, other than over-the-counter medication, prescribed? ___ Yes ___ No	

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<p>Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?  <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>If yes, state the nature of such treatments and expected duration of treatment.</p>
<p>2. Is the medical condition pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>If yes, expected delivery date:</p>
<p>3. 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 ):</p>	
<p><b>PART C: 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.</b></p>	
<p>4. Will the patient be incapacitated for a single continuous period of time , including any time for treatment and recover?  <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>If yes, estimate the beginning and ending dates for the period of incapacity:  Beginning Date:  Ending Date:</p>
<p>During this time, will the patient need care?  <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Explain the care needed by the patient and why such care is medically necessary?</p>
<p>5. Will the patient need to attend follow-up treatments, including any recovery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:</p>
<p>Explain the care needed by the patient, and why such care is medically necessary:</p>	
<p>6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?  <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Estimate the hours the patient needs care on an intermittent basis, if any: <input type="checkbox"/> hours per day; <input type="checkbox"/> days per week from _____ through _____</p>
<p>Explain the care needed by the patient, and why such care is medically necessary:</p>	
<p>7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal activities?  <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>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):</p> <p>Frequency: _____ times per _____ week(s) _____ month(s)</p> <p>Duration: _____ hours or _____ day(s) per episode</p>
<p>Does the patient need care during these flare-up?  <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Explain the care needed by the patient, and why such care is medically necessary:</p>

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**ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER:**

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Signature of Health Care Provider

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Date

**Return form to: Patient or BHSU Human Resources, 1200 University St Unit 9568, Spearfish SD 57799-9568 or FAX TO: 605-642-6055.**