

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

OMB Control Number: 1215-0181  
Expires: 12/31/2011

**SECTION I: For Completion by the EMPLOYER**

**INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally 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 and in accordance with 29 C.F.R. § 1630.14(c)(1), if the American with Disabilities Act applies.

Employer name and contact: \_\_\_\_\_

Employee's job title: \_\_\_\_\_ Regular work schedule: \_\_\_\_\_

Employee's essential job functions: \_\_\_\_\_

Check if job description is attached: \_\_\_\_\_

**SECTION II: For Completion by the EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II before giving this form to your 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 due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request, 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: \_\_\_\_\_  
First Middle Last

**SECTION III: For Completion by the HEALTH CARE PROVIDER**

**INSTRUCTIONS to the HEALTH CARE 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," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. 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: \_\_\_\_\_

Probable duration of condition: \_\_\_\_\_

**Mark below as applicable:**

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

\_\_\_ No \_\_\_ Yes. If so, dates of admission:

\_\_\_\_\_  
Date(s) you treated the patient for condition:

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

Was medication, other than over-the-counter medication, prescribed?

\_\_\_ No \_\_\_ Yes.

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 such treatments and expected duration of treatment:

\_\_\_\_\_  
2. Is the medical condition pregnancy? \_\_\_ No \_\_\_ Yes. If so, expected delivery date: \_\_\_\_\_.

3. 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:

\_\_\_\_\_  
4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (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 LEAVE NEEDED**

5. 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 so, estimate the beginning and ending dates for the period of incapacity: \_\_\_\_\_

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? \_\_\_No \_\_\_Yes

If so, are the treatments or the reduced number of hours of work medically necessary? \_\_\_No \_\_\_Yes

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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Estimate the part-time or reduced work schedule the employee needs, if any:

\_\_\_\_\_hour(s) per day; \_\_\_\_\_days per week from \_\_\_\_\_ through \_\_\_\_\_

7. 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:

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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





- I have previously provided my employer with sufficient written documentation confirming the covered military member's active duty or call to active duty status in support of a contingency operation.

**PART A: QUALIFYING REASON FOR LEAVE**

1. Describe the reason you are requesting FMLA leave due to a qualifying exigency (including the specific reason you are requesting leave):

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2. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military, a document confirming an appointment with a counselor or school official, or a copy of a bill for services for the handling of legal or financial affairs. Available written documentation supporting this request for leave is attached.  Yes  No  None Available

**PART B: AMOUNT OF LEAVE NEEDED**

1. Approximate date exigency commenced: \_\_\_\_\_  
Probable duration of exigency: \_\_\_\_\_

2. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency?  No  Yes.  
If so, estimate the beginning and ending dates for the period of absence:

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3. Will you need to be absent form work periodically to address this qualifying exigency?  No  Yes.  
Estimate schedule of leave, including the dates of any scheduled meetings or appointments: \_\_\_\_\_

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Estimate the frequency and duration of each appointment, meeting, or leave event, including any travel time (i.e., 1 deployment-related meeting every month lasting 4 hours):

Frequency: \_\_\_\_\_ times per \_\_\_\_\_ week(s) \_\_\_\_\_ month(s)

Duration: \_\_\_\_\_ hours \_\_\_\_\_ day(s) per event.

**PART C:**

If leave is requested to meet with a third party (such as to arrange for childcare, to attend counseling, to attend meetings with school or childcare providers, to make financial or legal arrangements, to act as the covered military member's representative before a federal, state, or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations), a complete and sufficient certification includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the telephone or fax number or e-mail address of the individual or entity). This information may be used by your employer to verify that the information contained on this form is accurate.

Name of Individual: \_\_\_\_\_ Title: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

E-mail: \_\_\_\_\_

Describe nature of meeting: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PART D:**

I certify that the information I provided above is true and correct.

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETE FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE EMPLOYER.**

Certification for Serious Injury or  
Illness of Covered Servicemember--  
For Military Family Leave (Family and  
Medical Leave Act)

OMB Control Number: 1215-0181

Expires: 12/31/2011

**Notice to the EMPLOYER INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a serious injury or illness of a covered servicemember to submit a certification providing sufficient facts to support the request for leave. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.310. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees or employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

**SECTION I: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee is Requesting Leave INSTRUCTIONS to the EMPLOYEE or COVERED SERVICEMEMBER:** Please complete Section I before having Section II completed. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a covered servicemember. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 C.F.R. §§ 2613.2614(c)(3). Failure to do so may result in a denial of an employee's FMLA request. 29 C.F.R. § 825.310(f). The employer must give an employee at least 15 calendar days to return this form to the employer.

**SECTION II: For Completion by a UNITED STATE DEPARTMENT OF DEFENSE ("DOD") HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider INSTRUCTIONS to the HEALTH CARE PROVIDER:** The employee listed on Page 2 has requested leave under the FMLA to care for a family member who is a member of the Regular Armed Forces, the National Guard, or the Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating.

A complete and sufficient certification to support a request for FMLA leave due to a covered servicemember's serious injury or illness includes written documentation confirming that the covered servicemember's injury or illness was incurred in the line of duty on active duty and that the covered servicemember is undergoing treatment for such injury or illness by a health care provider listed above. 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 employee is seeking leave.

**SECTION 1: For Completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the Employee Is Requesting Leave:** (This section must be completed first before any of the below sections can be completed by a health care provider.)

**Part A: EMPLOYEE INFORMATION**

Name and Address of Employer (this is the employer of the employee requesting leave to care for covered servicemember):

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Name of Employee Requesting Leave to Care for Covered Servicemember:

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First	Middle	Last
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Name of Covered Servicemember (for whom employee is requesting leave to care):

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First	Middle	Last
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Relationship of Employee to Covered Servicemember Requesting Leave to Care:  
 Spouse    Parent    Son    Daughter    Next of Kin

**Part B: COVERED SERVICEMEMBER INFORMATION**

(1) Is the Covered Servicemember a Current Member of the Regular Armed Forces, the National Guard or Reserves?    Yes    No

If yes, please provide the covered servicemember's military branch, rank and unit currently assigned to:

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Is the covered servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)?    Yes    No. If yes, please provide the name of the medical treatment facility or unit:

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(2) Is the Covered Servicemember on the Temporary Disability Retired List (TDRL)?    Yes    No

**Part C: CARE TO BE PROVIDED TO THE COVERED SERVICEMEMBER**

Describe the Care to Be Provided to the Covered Servicemember and an

Estimate of the Leave Needed to Provide the Care:

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SECTION II: For Completion by a United States Department of Defense ("DOD") Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider. **If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator).** (Please ensure that Section I above has been completed before completing this section.) Please be sure to sign the form on the last page.

**Part A: HEALTHCARE PROVIDER INFORMATION**

Health Care Provider's Name and Business Address:

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Type of Practice/Medical Specialty: \_\_\_\_\_

Please state whether you are either: (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; or (4) a DOD non-network TRICARE authorized private health care provider:

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Telephone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_ E-mail: \_\_\_\_\_

**PART B: MEDICAL STATUS**

- (1) Covered Servicemember's medical condition is classified as (Check One of the Appropriate Boxes):
- (VSI) Very Seriously Ill/Injured** - Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)
  - (SI) Seriously Ill/Injured** - Illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)
  - OTHER Ill/Injured** - a serious injury or illness that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank, or rating.
  - NONE OF THE ABOVE** (Note to Employee: If this box is checked,

you may still be eligible to take leave to care for a covered family member with a "serious health condition" under § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380 or an employer-provided form seeking the same information.)

(2) Was the condition for which the Covered Service member is being treated incurred in line of duty on active duty in the armed forces?  
 Yes  No

(3) Approximate date condition commenced: \_\_\_\_\_

(4) Probable duration of condition and/or need for care:  
\_\_\_\_\_  
\_\_\_\_\_

(5) Is the covered servicemember undergoing medical treatment, recuperation, or therapy?  Yes  No. If yes, please describe medical treatment, recuperation or therapy:  
\_\_\_\_\_  
\_\_\_\_\_

**PART C: COVERED SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER**

(1) Will the covered servicemember need care for a single continuous period of time, including any time for treatment and recovery?  Yes  No  
If yes, estimate the beginning and ending dates for this period of time: \_\_\_\_\_

(2) Will the covered servicemember require periodic follow-up treatment appointments?  
 Yes  No. If yes, estimate the treatment schedule:  
\_\_\_\_\_

(3) Is there a medical necessity for the covered servicemember to have periodic care for these follow-up treatment appointments?  Yes  No

(4) Is there a medical necessity for the covered servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)?  Yes  No. If yes, please estimate the frequency and duration of the periodic care:  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Health Care Provider: \_\_\_\_\_

Date: \_\_\_\_\_

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years, in accordance with 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETE FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE PATIENT.**

Designation Notice  
(Family and Medical Leave Act)

OMB Control Number: 1215-0181  
Expires: 12/31/2011

Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient. While use of this form by employers is optional, a fully completed Form WH-382 provides an easy method of providing employees with the written information required by 29 C.F.R. §§ 825.300(c), 825.301, and 825.305(c).

To: \_\_\_\_\_

Date: \_\_\_\_\_

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided. We have received your most recent information on \_\_\_\_\_ and decided:

\_\_\_\_\_ **Your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave.**

**The FMLA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave entitlement:**

\_\_\_\_\_ Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement: \_\_\_\_\_

\_\_\_\_\_ Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your FMLA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

**Please be advised (check if applicable):**

\_\_\_\_\_ You have requested to use paid leave during your FMLA leave. Any paid leave taken for this reason will count against your FMLA leave entitlement.

\_\_\_\_\_ We are requiring you to substitute or use paid leave during your FMLA leave.

\_\_\_\_\_ You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received,

your return to work may be delayed until certification is provided. A list of the essential functions of your position  is  is not attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.

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**Additional information is needed to determine if your FMLA leave request can be approved:**

The certification you have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than \_\_\_\_\_, unless it is not practicable under the (Provide at least seven calendar days) particular circumstances despite your diligent good faith efforts, or your leave may be denied.

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(Specify information needed to make the certification process complete and sufficient)

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We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

Your FMLA Leave request is Not Approved.

The FMLA does not apply to your leave request.

You have exhausted your FMLA leave entitlement in the applicable 12-month period.

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**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

It is mandatory for employers to inform employees in writing whether leave requested under the FMLA has been determined to be covered under the FMLA, 29 U.S.C. § 2617; 29 C.F.R. §§ 825.300(d), (e). It is mandatory for employers to retain a copy of this disclosure in their records for three years, 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10-30 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**

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

OMB Control Number: 1215-0181  
Expires: 12/31/2011

**SECTION I: For Completion by the EMPLOYER**

**INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the American with Disabilities Act applies.

Employer name and contact: \_\_\_\_\_

**SECTION II: For Completion by the EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II before giving this form to your family member or his/her 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. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request, 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: \_\_\_\_\_  
                    First                                    Middle                                    Last

Name of family member for whom you will provide 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: For Completion by the HEALTH CARE PROVIDER**

**INSTRUCTIONS to the 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. Page 3 provides space for additional information, should you need it. 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: \_\_\_\_\_

Probable duration of condition: \_\_\_\_\_

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

\_\_\_ No \_\_\_ Yes. If so, dates of admission:

\_\_\_\_\_  
Date(s) you treated the patient for condition:

\_\_\_\_\_  
Was medication, other than over-the-counter medication, prescribed?  
\_\_\_ No \_\_\_ Yes.

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

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 such treatments and expected duration of treatment:

\_\_\_\_\_  
2. Is the medical condition pregnancy? \_\_\_ No \_\_\_ Yes. If so, expected

delivery date: \_\_\_\_\_.

8. 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:**

9. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? \_\_\_No \_\_\_Yes

Estimate the beginning and ending dates for the period of incapacity: \_\_\_\_\_

During this time, will the patient need care? \_\_\_No \_\_\_Yes

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

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10. Will the patient require follow-up treatments, including any time for recovery? \_\_\_No \_\_\_Yes

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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Explain the care needed by the patient and why such care is medically necessary: \_\_\_\_\_

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11. Will the patient require care on an intermittent or reduced schedule

basis, including any time for recovery? \_\_\_No \_\_\_Yes.

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

\_\_\_\_\_hour(s) per day; \_\_\_\_\_days per week from \_\_\_\_\_ through \_\_\_\_\_

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

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12. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities?  
\_\_\_No \_\_\_Yes.

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

Does the patient need care during these flare-ups? \_\_\_No \_\_\_Yes.

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

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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**

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**