Certification of Health Care Provider for FAMILY MEMBER'S Serious Health Condition (Family and Medical Leave Act)

Return forms to: Fax: 316.941.5132 • Email: FMLA@sedgwick.gov

SECTION I: For Completion by Human Resources

INSTRUCTIONS: The Family and Medical Leave Act (FMLA) provides that Sedgwick County may require an employee seeking FMLA leave to care for a family member with a serious health condition to submit a medical certification issued by the family member's health care provider. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. 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. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

Sedgwick County generally must maintain records and documents relating to medical information, 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 employee personnel file and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Human Resources Representative: Kyelene Flaming, PHR, SHRM-CP – FMLA/ADA Specialist

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS: Please complete Section II ***before*** giving this form to your health care provider. Sedgwick County requires you submit a timely, complete, and sufficient medical certification to support your request for FMLA leave due to your family member's serious health condition. 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 Sedgwick County's Human Resources Representative listed above.

Employee name: _____
First Middle Last

Name of the family member for whom you will provide care: _____
First Middle Last

Select the relationship of the family member to you. *(Choose at least one)*

☐ Spouse ☐ Parent* ☐ Baby Bonding* ☐ Child, under age 18

☐ Child, over 18 who is incapable of self-care because of a mental or physical disability *(supplemental documentation required)*

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including in a common law marriage or same-sex marriage. The terms "child" and "parent" include ***in loco parentis*** relationships. An employee may take FML to care for an individual who assumed the obligations of a parent to the employee when the employee was a child or to care for a child for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary; however, documentation is required.

1. 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
   ☐ Psychological Comfort ☐ Physical Care ☐ Other_____
2. I am requesting: ☐ **CONTINUOUS** ☐ **INTERMITTENT** **Family Medical Leave**
3. Provide your **best estimate** for the amount of time (days/hours, including dates, if known) needed to care for your covered family member:_____
4. If a **reduced work schedule** is necessary to provide the care described, give your **best estimate** of the reduced schedule you are able to work. From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy).*
   I am able to work _____ *(hours per day)* _____ *(days per week).*
5. ***If your spouse works for Sedgwick County, please provide their name:** _____
6. **If requesting continuous leave to care for your family member, please provide a personal email address where you can be contacted** _____

Employee Signature: _____ **Date:** _____

Employee Name _____

SECTION III: For Completion by the HEALTH CARE PROVIDER

Please provide your contact information and complete all applicable parts of this Section then sign and date the form on the following page. 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 to care for a family member with a serious health condition. 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. You also may, but are not required to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

Family Member's Health Care Provider: *(Print Full Name)* _____

Health Care Provider's Business Address: _____

Name & 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. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. Please be specific. Do not use words such as "lifetime," "indefinitely," or other words which do not provide a specific timeframe. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, 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).

Patient's name: _____
First Middle Last

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

   _____

   _____

4. Check the box(es) for the questions below, as applicable. ***For all box(es) checked, the amount of leave needed must be provided in Part B on the following page.***

   ☐ **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): _____

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

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

   _____

   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. The estimated delivery date is: _____ *(mm/dd/yyyy)*. **NOTE:** If the request is for baby bonding only, please complete the date above and check **"None of the above"** then proceed to the signature on the next page.

OPTIONS CONTINUED ON NEXT PAGE

Employee Name _____

☐ **Chronic Conditions:** *(e.g. asthma, migraine headaches)* Due to the condition, 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)* Due to the condition, 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, restorative surgery)* Due to the condition, it is medically necessary for the patient to receive multiple treatments.

☐ **None of the above:** If none of the above condition(s) were checked, *(i.e., inpatient care, pregnancy)* no additional information is needed. Proceed to page the last page to sign and date the form.

5. Briefly describe relevant medical facts related to the condition(s) for which the employee is seeking FMLA for the care of their family member. *(e.g., dialysis)*_____

_____

PART B: AMOUNT OF LEAVE NEEDED

For the medical condition(s) checked in Part A, complete all that apply. 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" is not sufficient to determine the amount of time needed to be covered under Family Medical Leave (FML).**

CONTINUOUS COVERAGE

6. Due to the condition, the patient (☐ was / ☐ will be) **incapacitated for a CONTINUOUS period of time**. The period of total and continuous incapacity, including any time for treatment(s) and/or recovery will begin _____ *(mm/dd/yyyy)* through _____ *(mm/dd/yyyy)*.

INTERMITTENT COVERAGE

Sedgwick County approves intermittent leaves for a period of 6 months.

7. Due to the condition, the patient (☐ had / ☐ will have) **PLANNED MEDICAL TREATMENT(S) and/or APPOINTMENT(S)** on the following date(s): _____

   The employee will need to be absent for _____ (☐ hours / ☐ days) per appointment/treatment.

8. Due to the condition, the patient (☐ was / ☐ will be) **REFERRED TO OTHER HEALTH CARE PROVIDER(S)** for evaluation and/or treatment(s). State the nature of such treatments: *(e.g. cardiologist, physical therapy, etc.)* _____

   _____

   Over the next 6 months, the number, length and frequency of the scheduled treatment(s)/appointment(s), including any period(s) of recovery *(e.g. 3 days/week)* will be _____ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ (☐ hours / ☐ days) per treatment(s)/appointment(s).

9. Due to the patient's condition, it (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work periodically to care for the patient during any ***EPISODES OR FLARE-UPS***. Provide how often (frequency) and how long (duration) the episodes of incapacity will likely last when the employee cannot work due to caring for their covered family member.

   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.

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