Medical Certification from Health Care Provider for EMPLOYEE'S Serious Health Condition Family and Medical Leave Act

Return form directly to SEDGWICK COUNTY HUMAN RESOURCES

FMLA Dedicated Fax: 316.941.5132 • Email Securely to FMLA@sedgwick.gov

Sedgwick County Human Resources Contact: Kyelene Flaming – FMLA/ADA Specialist – 316.660.7056

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 completed by the employee's health care provider. Sedgwick County maintains records and documents relating to medical certifications, and medical histories of employees created for FMLA purposes, as confidential medical records kept in a separate file from the employee's personnel file.

SECTION I: To be completed by the EMPLOYEE

INSTRUCTIONS: Sedgwick County policy 4.711 requires you to submit a timely, complete, and sufficient medical certification supporting your request for job protected absences due to your own serious health condition. **Submission of this medical certification form is required by Sedgwick County in order to obtain and/or retain leave protections.** Failure to provide complete and sufficient medical certification may result in the denial or delay of your FMLA request. **You have 15 calendar days from the date you receive this form to return it to Sedgwick County – Division of Human Resources. *DO NOT SUBMIT THIS FORM TO YOUR SUPERVISOR or another employee.***

Employee name: _____
First Middle Last

Scheduled Work Days: _____ Standard work hours: _____

Personal (non-Sedgwick County) ***email address*** to access while on leave: _____

Temporary mailing address, if different from what is in Employee Central:

_____

Which of the following best describes your need for leave under the FMLA?

☐ Pregnancy ☐ Illness ☐ Injury ☐ Surgery ☐ Baby Bonding*

I am requesting: ☐ CONTINUOUS FML – Scheduled dates of absence _____

Baby Bonding leave is continuous leave ONLY and will not begin until the delivery/placement date. (Birth Confirmation Letter for live birth or court documentation of adoption/placement required). No health care provider information needed.

☐ INTERMITTENT FML – Effective date _____

Based upon your condition, if you anticipate periods of incapacity which will prevent you from performing one or more of your job functions while at work, please contact the FMLA/ADA Specialist to discuss.

Recertification: ☐ Yes ☐ No ***Recertification is required by Sedgwick County every 6 months***

Acknowledgments:

I hereby consent for my health care provider to release information to Sedgwick County Human Resources regarding my health condition: ☐ Yes ☐ No

I hereby provide my consent for Sedgwick County Human Resources to contact my health care provider to clarify and/or to authenticate any information provided on this form. ☐ Yes ☐ No

I understand that it is my responsibility to ensure that my health care provider completes this form and returns it to Sedgwick County Human Resources within 15 calendar days of receipt of this form from Human Resources.

Employee Signature: _____ Date: _____

Fax completed form confidentially to: Sedgwick County FMLA at 316.941.5132 or email securely to FMLA@sedgwick.gov

Employee Name _____

SECTION II: To be completed by the HEALTH CARE PROVIDER ONLY

Your patient has requested job protected leave under the FMLA. Sedgwick County requires that the employee submit a timely, complete, and sufficient medical certification to support their request for FMLA leave due to the employee's 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***. ***Please refer to the Definitions of a Serious Health Condition chart provided on the last page or by visiting*** https://www.commerce.gov/hr/employees/leave/fmla/serious-health-condition.

PART A: MEDICAL FACTS OF PATIENT'S CONDITION(S)

Limit your response only 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. **SPECIFIC INFORMATION IS REQUIRED.** Words such as "lifetime," "indefinitely," or those that do not provide a specific amount of time will not be sufficient to designate leave. **Following completion of Part A, Part B is required to support the AMOUNT OF LEAVE NEEDED for continuous and/or intermittent absences for appointments, treatments, episodes or a reduced work schedule.** 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).

Do NOT submit the patient's medical file. If additional clarifying information is needed, attach a separate page.

1. Based upon the patient's condition and prescribed treatment, check the boxes as applicable. ***Specifics regarding the amount of leave needed must be provided in Part B.***

☐ A) **Inpatient Care:** (overnight stay in a hospital, hospice, or residential medical care facility).

Dates admitted: from _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*.

☐ B) **Incapacity Plus Treatment**: *(e.g. outpatient surgery, infections requiring antibiotics/continuing treatment, etc.)*
Due to the condition, the patient is/was incapacitated for **three (3) or more consecutive, full calendar days**: from _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*.

The patient will need to have continuing treatments at least twice per year. ☐ YES ☐ NO
The patient has been prescribed medication for condition other than over-the-counter. ☐ YES ☐ NO
The patient will be evaluated and/or treated by other health care provider(s). ☐ YES ☐ NO
(e.g. specialist referral(s), physical therapy, etc.)

☐ C) **Pregnancy:** Incapacity causing absences due to pregnancy and/or prenatal care.
Estimated delivery date (EDD): _____ *(mm/dd/yyyy).*

☐ D) **Chronic Health Condition:** _____ *(e.g. asthma, migraines)* ☐ YES ☐ NO
It is medically necessary for the patient to have treatments/appointments at least twice per year.

☐ E) **Permanent or Long Term Condition:** _____ ☐ YES ☐ NO
Condition is permanent/long term requiring ongoing treatment from a health care provider.

☐ F) **Multiple Treatments:** *(e.g. for cancer, kidney disease, restorative surgery, physical therapy, etc.)* ☐ YES ☐ NO
Due to the condition, it is medically necessary for the patient to receive multiple treatments.

2. Approximate date condition commenced or patient was diagnosed: _____ *(mm/dd/yyyy)*

3. Probable duration of condition: _____

4. Nature and estimated duration of treatment prescribed: _____

_____

5. **REQUIRED: Describe relevant medical facts related to the condition for which the employee seeks leave including symptoms, diagnosis, type of surgery and/or scope of prescribed continuing treatment.**
(e.g. Pt diagnosed with: IBS, migraines, asthma, dialysis, chemotherapy, etc. and has been prescribed the following treatment…)

_____

_____

_____

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Employee Name _____

PART B: TYPE AND AMOUNT OF LEAVE NEEDED

For the item(s) checked in Part A, provide specifics for each type of leave needed. For questions related to frequency or duration of a condition, treatment plan, etc., give **your BEST ESTIMATE based upon your medical knowledge, experience, and examination of the patient. Terms such as "lifetime," "unknown," or "indeterminate" are insufficient and will be considered incomplete for purposes of designating the request, which may result in a delay or denial of the employee's request.**

CONTINUOUS LEAVE for CONSECUTIVE DAY ABSENCES *(Additional Return to Work Certification Form Required)*

6. Due to the condition, the patient (☐ was / ☐ will be) **incapacitated and unable to work *CONTINUOUSLY***

from_____ *(mm/dd/yyyy)* through _____ *(mm/dd/yyyy)*.

INTERMITTENT COVERAGE – Scheduled Appointments/Treatments, Unplanned Episodes, Reduced Work Schedule

Sedgwick County approves intermittent leave cases for a period of six (6) months.

7. MEDICAL APPOINTMENTS AND/OR TREATMENT(S)

Is it medically necessary for the employee to be absent from work for medical appointments and/or treatments due to the condition? ☐ YES ☐ NO

If yes, provide estimated treatment schedule. Include time the employee will be absent for appointment, travel and recovery if the appointments are/will be scheduled during the employee's scheduled workday.

Frequency: _____ times per _____ week(s) OR _____ month(s)

Duration: _____ hour(s) OR _____ days(s) per appointment/treatment

APPOINTMENTS/TREATMENT CERTIFIED FROM _____*(mm/dd/yyyy)* through_____ *(mm/dd/yyyy)*.

8. EPISODE-RELATED ABSENCES

Is it medically necessary for the employee to be absent from work during flare-ups? ☐ YES ☐ NO

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of incapacity the employee may experience when they are not able to be at work.

Frequency: _____ times per _____ week(s) **OR** _____ month(s)

Duration: _____ hour(s) **OR** _____ days(s) per episode

9. REDUCED WORK SCHEDULE

Due to the condition, is it medically necessary for the employee to work less than their regularly assigned work schedule? ☐ Yes ☐ No

The employee is approved to work _____ hours per day and/or a total of _____ hours per week.

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

By signing this form, I certify that I am the health care provider for the above-named patient and that all information on this form is true and correct to the best of my knowledge.

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

Health Care Provider's Name: *(Print Legibly)* _____

Name and Title of Staff Member *(if not completed by the Health Care Provider)* _____

FULL Name and Business Address of Practice:_____

_____

Medical Practice/Specialty: _____ Phone: _____ Fax: _____

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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.