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

**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: 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‡ ☐ Foster Placement‡ ☐ Adoption‡ ☐ Child, under age 18*

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

If requesting FMLA for your child, please provide the child's date of birth (mm/dd/yyyy): ______________

†**Spouse:** 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.
‡FMLA for Baby Bonding, Foster Placement, or Adoption is only available for one (1) year from the date of birth or placement.

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 required to provide care, give your **best estimate** of the reduced schedule you are able to work. From __________ *(mm/dd/yyyy)* to __________ *(mm/dd/yyyy)* ______ *(hours per day)* ______ *(days per week).*
5. **If requesting continuous leave, please provide a personal email address where you can be contacted during your absence:** ______________________________

**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 has been active 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:**_____________________

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