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

U.S. Department of Labor Wage and Hour Division



DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.

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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. 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.

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Additionally, you may not request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, 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 Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

(1) Employee name:				
	First	Middle	Last	
(2) Employer name:			Date:	(mm/dd/yyyy)
			(List date certification reques	sted)
(3) The medical certification	must be returned by			(mm/dd/yyyy)
(Must allow at least 15 cale	endar days from the date request	ed, unless it is not feasible despite the	e employee's diligent, good faith efforts.)	(3337)
(4) Employee's job title:			Job description is /	is not attached.
Employee's regular work	schedule:			
Statement of the employe	ee's essential job functions:			
•	the employee's position are dete	·	he employee held at the time the employ	ee notified the

SECTION II - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient has requested leave under the FMLA. 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 due to the serious health condition of the employee. 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**. For more information about the definitions of a serious health condition under the FMLA, see the chart on page 4.

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.

Emplo	yee Name:			
Health	Care Provider's name: (Print)			
Health	Care Provider's business address:			
Type of	f practice / Medical specialty:			
Telenh	one:	Fax:		
Гогория			_ E-mail:	
PART	A: Medical Information			
based informategular tests, a the emp	upon your medical knowledge, ex ation about the amount of leave of daily activities due to the condition as defined in 29 C.F.R. § 1635.3(f), ployee's family members, 29 C.F.R.	perience, and examination of needed. Note: For FMLA purpon, treatment of the condition, or genetic services, as defined in § 1635.3(b).	is seeking FMLA leave. Your answ the patient. After completing Par oses, "incapacity" means the inabilit recovery from the condition. Do no n 29 C.F.R. § 1635.3(e), or the man	rt A, complete Part B to provide by to work, attend school, or perform of provide information about genetic nifestation of disease or disorder in
(2) Dro	uide vour heat estimate of how lon	or the condition leated or will lea		
(Z) P10	vide your best estimate or now ion	g the condition lasted of will las	st:	
(3) Che	eck the box(es) for the questions be	low, as applicable. For all box(es) checked, the amount of leave ne	eeded must be provided in Part B.
	· 	<u>—</u>	oe) admitted for an overnight stay in s):	•
	Incapacity plus Treatment: (e.g.			
	, -		d to be) incapacitated for more tha	n three
			d/yyyy) to (mm/	
):	
			of continuing treatment under the sur- tr-the-counter) or therapy requiring s	
	Pregnancy: The condition is pregr	nancy. List the expected deliv	very date: (ı	mm/dd/yyyy).
	Chronic Conditions : (e.g. asthmat treatment visits at least twice per y		the condition, it is medically necess	ary for the patient to have
			al stages of cancer) Due to the cond are provider (even if active treatmer	
	Conditions requiring Multiple Transcessary for the patient to receive		treatments, restorative surgery) Du	e to the condition, it is medically
	None of the above: If none of the needed. Go to page 4 to sign and		ted, (i.e., inpatient care, pregnancy)	no additional information is

Employee Name:		
(4) If needed, briefly describe other appropriate medical facts rela of nebulizer, dialysis)	ited to the condition(s) for which the emplo	yee seeks FMLA leave. (e.g., use
PART B: Amount of Leave Needed		
For the medical condition(s) checked in Part A, complete all that condition, treatment, etc. Your answer should be your best estim patient. Be as specific as you can; terms such as "lifetime," "unknown"	nate based upon your medical knowledge,	experience, and examination of the
(5) Due to the condition, the patient (had / will have) pla (e.g.psychotherapy, prenatal appointments) on the following dates		•
(6) Due to the condition, the patient (was / will be) refe	erred to other health care provider(s) for	evaluation or treatment(s).
State the nature of such treatments: (e.g. cardiologist, physical the	erapy)	
Provide your best estimate of the beginning date	(mm/dd/yyyy) and end date	(mm/dd/yyyy).
for the treatment(s).		
Provide your best estimate of the duration of the treatment(s), inc	cluding any period(s) of recovery (e.g. 3 da	ays/week)
(7) Due to the condition, it is medically necessary for the employed	e to work a reduced schedule .	
Provide your best estimate of the reduced schedule the employe	ee is able to work. From	(mm/dd/yyyy)
to (mm/dd/yyyy) the employee is able to v	work: (e.g., 5 hours/day, up to 25 hours a v	veek)
(8) Due to the condition, the patient (was / will be) inca	apacitated for a continuous period of tin	ne, including any time
for treatment(s) and/or recovery.		
Provide your best estimate of the beginning date	(mm/dd/yyyy) and end date	(mm/dd/yyyy).
for the period of incapacity.		
(9) Due to the condition, it ($\ \ \ \ \ \ \ \ \ \ \ \ \ $	ally necessary for the employee to be abse	ent from work on an
intermittent basis (periodically), including for any episodes of inca (frequency) and how long (duration) the episodes of incapacity wi		r best estimate of how often
Over the next 6 months, episodes of incapacity are estimated to o	occur	times per
(day week month) and are likely to last approxin	nately (hours days) per episode.

PART C: Essential Job Functions						
If provided, the information in Section I question #4 may be used to answer this question. If the employer fails to provide a statement of the employee's essential functions or a job description, answer these questions based upon the employee's own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be not able to perform the essential job functions of the position during the absence for treatment(s).						
(10) Due to the condition, the employee (was not able / is not able / [will not be able) to perform one or mo	re of the				
essential job function(s). Identify at least one essential job function the employ	ee is not able to perform:					
Signature of Health Care Provider	Date:	(mm/dd/yyyy)				
Definitions of a Serious Health Condition (See 29 C.F.R. §§ 825.11	3115)					
Inpatient Care	,					
 An overnight stay in a hospital, hospice, or residential medical car Inpatient care includes any period of incapacity or any subsequen 		night 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 treatment or period of incapacity relating to the same condition, that also		ny subsequent				
 Two or more in-person visits to a health care provider for treatextenuating circumstances exist. The first visit must be within 						
 At least one in-person visit to a health care provider for treating results in a regimen of continuing treatment under the super- provider might prescribe a course of prescription medication 	vision of the health care provider. For e	xample, the health				
Pregnancy: Any period of incapacity due to pregnancy or for prenatal	care.					
Chronic Conditions : Any period of incapacity due to or treatment for a asthma, migraine headaches. A chronic serious health condition is one supervised by the provider) at least twice a year and recurs over an exepisodic rather than a continuing period of incapacity.	e which requires visits to a health care p	orovider (or nurse				
Permanent or Long-term Conditions : A period of incapacity which is treatment may not be effective, but which requires the continuing supe disease or the terminal stages of cancer.						
Conditions Requiring Multiple Treatments: Restorative surgery afte likely result in a period of incapacity of more than three consecutive, fu						

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 15 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 Avenue, N.W., Washington, D.C. 20210.

Employee Name: