Family & Medical Leave Act (FMLA) Certification of Family Member’s Serious Health Condition

**SECTION I – For completion by employee**

- You must submit a certification to support your request for FMLA within 15 calendar days of your employer’s request for certification. **Not doing so may result in denial of your request.**
- You must ensure that your family member’s health care provider completes Section II and Section III or IV of this form and returns it to you.
- Return the certification form to the Disability Management Office: 400 S. Pine St., P.O. Box 30002, Lansing, MI 48909 or fax to (517) 241-9926.

<table>
<thead>
<tr>
<th>1. Employee’s Full Name:</th>
<th>2. Employee ID#:</th>
<th>3. Covered Family Member’s Full Name:</th>
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</table>

4. Relationship of Covered Family Member to you: [ ] Spouse  [ ] Parent  [ ] Child

If family member is your child, please provide the child’s date of birth:

5. Describe the care you will provide to your family member and estimate the leave needed to provide the care:

Employee’s Signature  Date:

**SECTION II – For completion by health care provider**

The employee listed above has requested leave under the FMLA to care for your patient:

- Ensure that Section I above has been completed before completing Sections II and III or IV.
- Answer all applicable questions fully and completely based on your medical knowledge, experience, and examination of the patient.
- Be as specific as you can, but limit your responses to the patient’s condition for which the employee is requesting leave.
- Attach additional sheets if more space is needed.
- Form must be signed and dated.

<table>
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<tr>
<th>1. Approximate date condition commenced:</th>
<th>2. Probable duration of condition:</th>
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3. Was the patient admitted overnight in a hospital, hospice, or residential medical care facility? [ ] Yes  [ ] No

If yes, list the dates of admission:

4. List the dates you treated the patient for the condition:

5. Will the patient need to have treatment visits at least twice per year due to the condition? [ ] Yes  [ ] No

6. Was medication, other than over-the-counter medication, prescribed? [ ] Yes  [ ] No

7. Was the patient referred to other health care providers for evaluation or treatment? [ ] Yes  [ ] No

If yes, state the nature of such treatments and expected duration of treatment:

8. Is the medical condition pregnancy? [ ] Yes  [ ] No

If yes, expected delivery date:

9. Provide a diagnosis and any relevant medical facts (symptoms, regimen of treatment) related to the patient’s condition:
### SECTION III - CONTINUOUS HEALTH CONDITION
(Employee needs to be off work full-time to care for the patient)

10. Will the patient be incapacitated for a single continuous period of time, including any time for treatment or recovery?  
   - Yes  
   - No

   If yes, please estimate the start and end dates for the period of incapacity:
   
   ______________ through ______________

   Estimated start date       Estimated end date

   If yes, will the employee need to be off work for a single continuous period of time to provide care to the patient?  
   - Yes  
   - No

   If yes, please estimate the start and end dates for the period of time the employee will need to be off work:
   
   ______________ through ______________

   Estimated start date       Estimated end date

   If yes, please explain the care the employee will need to provide to the patient and why such care is medical necessary:

### SECTION IV - INTERMITTENT HEALTH CONDITION
(Employee needs to be off work intermittently to care for the patient)

11. Will the employee require leave on an intermittent basis to provide transportation and/or attend follow-up appointments/treatments with the patient?  
   - Yes  
   - No

   If yes, please estimate the patient’s appointment/treatment schedule, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

   **Appointment/Treatment schedule:** ___________________________ per ☐ day  ☐ week  ☐ month

   **Dates of scheduled appointments:** ___________________________ (mm/dd/yy)

   **Time required for each appointment, including any recovery period:** ___________________________ (minutes, hours, days)

   ______________ through ______________

   Estimated start date       Estimated end date

   If yes, please explain the care needed by the patient and why such care is medically necessary:

12. Will the patient’s condition require the employee to be off work on an intermittent or reduced schedule basis to provide care to the patient, including time for recovery?  
   - Yes  
   - No

   If yes, please estimate the amount of time that the employee may be off work on an intermittent or reduced schedule basis:

   ________ hours per day; ________ days per week from ______________ through ______________.

   If yes, please explain the care needed by the patient and why such care is medically necessary:

13. Will the patient’s condition cause episodic flare-ups preventing the patient from participating in normal daily activities, during which the employee will need to be off work to provide care to the patient?  
   - Yes  
   - No

   If yes, based upon the patient’s medical history and your knowledge of the medical condition, please estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months:

   **Frequency:** ________ times per ________ week(s) ________ month(s).  **Duration:** ________ hour(s) or ________ day(s) per episode

   If yes, please explain the care needed by the patient and why such care is medically necessary:

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**Signature of Health Care Provider**

**Date**

**Health Care Provider’s Name and Business Address (Please Print):**

**Type of Practice / Medical Specialty:** ☐ Telephone:

**Fax:**