CS-1839
REV 6/2019

STATE OF MICHIGAN
CIVIL SERVICE COMMISSION

FAMILY & MEDICAL LEAVE ACT (FMLA)
CERTIFICATION OF FAMILY MEMBER'S SERIOUS HEALTH CONDITION

PLEASE PRINT LEGIBLY

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.

1. Employee's Full Name:	2. Employee ID#:	3. Covered Family Member's Full Name:

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.

1. Approximate date condition commenced:	2. Probable duration of condition:

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 medically 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:

Signature of Health Care Provider		**Date**
Health Care Provider's Name and Business Address (Please Print):		
Type of Practice / Medical Specialty:	Telephone:	Fax: