

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 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:

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