CS-1844
REV 4/2023

STATE OF MICHIGAN
DEPARTMENT OF CORRECTIONS

FAMILY & MEDICAL LEAVE ACT (FMLA)
CERTIFICATION OF EMPLOYEE'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 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 Unit:
  PO Box 30831, Lansing, MI 48909 or fax to 517- 241-6898.

1. Employee Full Name:	2. Employee ID #:
3. Employee Job Title:	4. Employee Regular Work Schedule:

5. Employee's Essential Job Functions (also refer to any attached job description):

SECTION II – For completion by health care provider

The employee listed above has requested leave under the FMLA:

- 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 condition for which the patient needs 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. Based on the essential job functions in the attached job description (or based upon the employee's own description of his or her job functions if no job description is provided), is the employee unable to perform any of the job functions due to the condition? ☐ Yes ☐ No

   If yes, identify the job functions that the employee is unable to perform:

10. Provide a diagnosis and any relevant medical facts (symptoms, regimen of treatment) related to the patient's condition:

SECTION III - CONTINOUS HEALTH CONDITION – For completion by health care provider

11. Will the employee be incapacitated for a **single** continuous period of time due to his or her medical condition, including any time for treatment or recovery?

☐ Yes ☐ No

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

_________________ through _________________
Estimated start date Estimated end date

SECTION IV - INTERMITTENT HEALTH CONDITION – For completion by health care provider

12. Does the medical condition require the employee to attend follow-up treatment appointments or work a reduced schedule?

☐ Yes ☐ No

If yes, estimate the number of appointments and/or the reduced work schedule that the employee needs.

☐ Follow-up treatment schedule and appointments:

Treatment schedule: __________________________________ (daily, weekly, monthly)

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

☐ Work part-time or on a reduced schedule:

_______Hours per day

_______Days per week

_________________ through _________________
Estimated start date Estimated end date

13. Will the condition cause episodic flare-ups preventing the employee from performing their job functions and is it medically necessary for the employee to be absent from work during the flare-ups?

☐ Yes ☐ No

If yes, explain why the absence is medically necessary:

Based upon the medical history and your knowledge of the medical condition, estimate both the frequency of flare ups and the duration of related incapacity over the next 6 months (e.g., one episode every 3 months lasting 1-2 days):

Frequency:

____ times per ____ week **OR**____ times per ____ month

Duration:

____ hours per episode **OR** ____ days per episode

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