CS-1807
1/2009

State of Michigan
Civil Service Commission

CERTIFICATION OF FAMILY MEMBER'S SERIOUS HEALTH CONDITION (FMLA)

SECTION I – For completion by employee. You must submit a certification to support your request for FMLA leave due to a serious health condition of a covered family member within 15 calendar days. Not doing so may result in denial of your request. Please complete Section I before having your relative's health care provider complete Section II.

1. Employee's Full Name	2. Covered Family Member's Full Name

3. Relationship of Covered Family Member to You: ☐ Spouse ☐ Parent ☐ Child

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

4. 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. Answer fully and completely all applicable parts. Please answer all questions 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. Please ensure that Section I above has been completed before completing this section. Please attach additional sheets if more space is needed. Please be sure to sign the form.

1. Health Care Provider's Name and Business Address	2. Type of Practice/Medical Specialty
3. Telephone:	4. Fax:
5. Approximate date condition commenced:	6. Probable duration of condition:

7. Was the patient admitted overnight in a hospital, hospice, or residential medical care facility? ☐ Yes ☐ No

If yes, list the dates of admission:

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

9. Was medication, other than over-the-counter medication, prescribed? ☐ Yes ☐ No

10. Will the patient need to have treatment visits at least twice per year due to the condition? ☐ Yes ☐ No

11. 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 the treatments:

12. Is the medical condition pregnancy? ☐ Yes ☐ No If yes, expected delivery date:

13. Describe any other relevant medical facts related to the condition (e.g., symptoms, diagnosis, regimen of treatment).

14. Will the patient be incapacitated for a single continuous period of time, including any time for treatment or recovery, and will the patient require care during this period? ☐ Yes ☐ No
If yes, please estimate the beginning and ending dates for this period:

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

15. Will the patient require follow-up treatments, including any time for recovery? ☐ Yes ☐ No
If yes, please estimate the treatment schedule, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

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

16. Will the patient require care on an intermittent or reduced schedule basis, including time for recovery? ☐ Yes ☐ No
If yes, please estimate the hours the patient needs care on an intermittent basis, if any:

_____ 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:

17. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities and will the patient need care during these flare-ups? ☐ 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 ____ weeks ____ months. **Duration:** ____ hours or ____ days 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**