EMPLOYEE HEALTH CARE CERTIFICATION

The Family and Medical Leave Act (FMLA) provides that we may require you to submit a medical certification when you request FMLA leave for your serious health condition. We must give you **at least 15 calendar days** to provide the certification. **If you fail to provide complete and sufficient medical certification, your FMLA leave request may be denied.** Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla

Take this form ONLY and your job description to your doctor for them to fill out.

SECTION I – EMPLOYER

This form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. We may not ask you to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Additionally, we may not request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

ATTENTION HEALTH CARE PROVIDER, please do one of the following:

1. Give to employee to return to HR
2. Fax directly to HR at 928-753-8908

(1) Employee name: _____

(2) Employer: Superior Court in Mohave County

(3) Date: _____

(4) The medical certification must be returned by_____
You will be given 15 calendar days from the date of this form unless it is not feasible despite your diligent, good faith efforts.

(5) Employee's Job Title:_____

Employee's regular work schedule:_____

Job Description (☐ is/ ☐ is not) attached

Statement of the employee's essential job functions:_____

We must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of your or your family members created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

SECTION II - HEALTH CARE PROVIDER MUST FILL OUT THIS PORTION

ATTENTION HEALTH CARE PROVIDER: Please provide your contact information, complete all relevant parts of this Section, and sign and date the form below. Your patient has requested leave under the FMLA to care for their own serious health condition. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave for their own serious health condition. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves inpatient care or continuing treatment by a health care provider. For more information about the definitions of a serious health condition under the FMLA, see the chart at the end of the form.

You also may provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment so that we can determine if the employee qualifies for FMLA.

Health Care Provider's name: *(Print)*_____

Health Care Provider's business address: _____

Type of practice / Medical specialty_____

Telephone:_____Fax: _____

E-mail: _____

PART A: Medical Information

Limit your response to the medical condition(s) for which the patient is seeking FMLA leave for your patient. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the patient, 29 C.F.R. § 1635.3(b).

(1) State the approximate date the condition started or will start. (mm/dd/yyyy) _____

(2) Provide your **best estimate** of how long the condition lasted or will last: _____

_____

(3) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

☐ **Inpatient Care**: The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____

☐ **Incapacity plus Treatment**: *(e.g. outpatient surgery, strep throat)*
Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for ***more than* three consecutive, full calendar days** from:

_____*(mm/dd/yyyy)* to _____*(mm/dd/yyyy)*.

The patient (☐ was / ☐ will be) seen on the following date(s): _____

_____

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

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

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
☐ Yes ☐ No If "yes", state the nature of such treatments and expected duration of treatment:

_____

Is the condition the result of voluntary cosmetic surgery? ☐ Yes ☐ No
Conditions for which cosmetic treatments are administered (such as most treatments for acne or plastic surgery) are not "serious health conditions" unless inpatient hospital care is required or unless complications develop. Restorative dental or plastic surgery after an injury or removal of cancerous growths are serious health conditions provided all the other conditions of this regulation are met.

☐ **Pregnancy**: The condition is pregnancy. List the expected delivery date:_____ *(mm/dd/yyyy)*.

☐ **Chronic Conditions**: *(e.g., asthma, migraine headaches)* Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Permanent or Long-Term Conditions**: *(e.g., Alzheimer's, terminal stages of cancer)* Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Conditions requiring Multiple Treatments**: (*e.g., chemotherapy treatments, restorative surgery)* Due to the condition, it is medically necessary for the patient to receive multiple treatments.

☐ **None of the above**: If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed and **FMLA will not be approved for the patient**. Go to page 4 to sign and date the form.

(4) Briefly describe other appropriate medical facts (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment) related to the condition(s) for which the patient seeks FMLA leave that would help us determine if the patient is eligible for FMLA. The more information you provide the easier it is for us to determine eligibility. *(e.g., use of nebulizer, dialysis*):

_____

_____

_____

PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. **Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage.**

(5) Due to the condition, the patient (☐ was / ☐ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery. This section is for a single block of time that the patient will need to be absent from work. If the patient will need time off intermittently after this single block of uninterrupted time, please also fill out number(s) 6, 7, 8, and/or 9 below.

Provide your best estimate of the beginning date _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the period of incapacity.

(6) Due to the condition, it (☐ was / ☐ is / ☐ will be) **medically necessary for your patient to be absent from work on an intermittent unscheduled basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last. *(e.g., 3 times per week lasting 6 to 8 hours: or 1 day per week lasting 1 day per episode).*

Over the next (☐ 6 months/ ☐ 12 months)
Episodes of incapacity are estimated to occur _____times per (☐ day; ☐ week; ☐ month)

and are likely to last approximately_____☐ hours OR _____ ☐days per episode

(7) Due to the condition, it is medically necessary for the employee to work a **reduced schedule**. Provide your **best estimate** of the reduced schedule the patient is able to work.

From _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy) the patient can work. Please be as specific as possible as to the appropriate schedule for your patient both to how many hours per day, how many days per week, total hours worked per week, and any specific shift or time period during a day to be worked. *(e.g., 5 hours/day, up to 25 hours a week;3 days per week up to 8 hours per day; 5 days per week/4hours per day in the morning only; no more than 20 hours per week with no more than 8 hours per day)*

_____

(8) Due to the condition, the patient (☐ had / ☐ will have) **planned medical treatment(s) (scheduled medical visits)** *(e.g. psychotherapy, dialysis, injections)*

State the nature of such treatments: *(e.g. cardiologist, physical therapy)*_____

_____

Provide your best estimate of the beginning date_____*(mm/dd/yyyy)* and end

date_____ *(mm/dd/yyyy)* for the treatment(s).

The patient will need to be absent from work for the entire or part of the workday for planned medical treatment. If you know the date, please list them. Please describe the amount of time needed (e.g. 2-4 hours for 3 time per week; 8 hours once per month; 2 days per week for 6 months) Provide your best estimate of the duration of the treatment(s), including any period(s) of recovery *(e.g. 3 days/week for 2 hours per appointment, one full day a week off)*

_____

(9) Due to the condition, the patient (☐ was / ☐ will be) **referred to other health care provider**(s) for evaluation or treatment(s). State the nature of such treatments: *(e.g. cardiologist, physical therapy)*

_____

Provide your **best estimate** of the beginning date_____*(mm/dd/yyyy)* and end date_____ *(mm/dd/yyyy)* for the treatment(s).

Provide your best estimate of the duration of the treatment(s), including any period(s) of recovery *(e.g., 3 days/week for 2 hours per appointment, one full day a week off)*

_____

PART C: Essential Job Functions

Use the information Section I question #4 or the attached job description (if the box is checked) to answer this question. **An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, inpatient care, or surgery and subsequent recovery, for a serious health condition is considered to be not able to perform the essential job functions of the position during the absence for treatment(s)**.

(10) Due to the condition, the patient (☐ was not able / ☐ is not able / ☐ will not be able) to perform one or more of the essential job function(s). Identify at least one essential job function the patient is not able to perform:

_____

_____

Signature of
Health Care Provider _____ **Date** _____ *(mm/dd/yyyy)*

Definitions of a Serious Health Condition *(See 29 C.F.R. §§ 825.113-.115)*
Inpatient Care
• An overnight stay in a hospital, hospice, or residential medical care facility. • Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.
Continuing Treatment by a Health Care Provider (any one or more of the following)
Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment

or period of incapacity relating to the same condition, that also involves either:

- Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or,
- At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.

Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.

Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.

Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.

Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.