

Medical Certification for FMLA – Employee

Your Healthcare Provider must complete and return this form directly to FMLASource by _____

Name: _____ FMLA ID Number: _____

Company Name: _____

Step 1: Reason for Leave

1) Healthcare Provider must indicate if the employee's condition is a FMLA "serious health condition." Please check any and all that apply.

Pregnancy



I certify the above employee is/has been/will be:

Incapacitated* due to pregnancy

Receiving prenatal care

Expected delivery date: _____

Incapacitated* to care for a newborn child

Medical Condition



I certify that the above employee is/has been/will be:

Incapacitated* for more than three consecutive days AND received treatment** at least 2 times for this condition.

Incapacitated* for more than three consecutive days AND received treatment** for this condition AND prescribed a regimen of continuing treatment (i.e. therapy, Rx).

Incapacitated* by or out of work to receive treatment** for a chronic serious health condition which requires:

1) Periodic visits/treatment and

2) Continues over extended period of time and

3) Causes episodic or continuing incapacity.*

Incapacitated* by a permanent/long-term condition for which patient is undergoing continuing treatment** (i.e. Alzheimer's, severe stroke).

Hospital Stay



I certify that the above employee is/has been/will be:

An inpatient in a hospital, hospice or residential medical care facility.

Out of work to receive treatment** for a condition connected to a previous inpatient stay.

Recovering from inpatient stay and incapacitated.*

I certify that:

None of the above conditions apply.

**Incapacity is defined as inability to work or perform regular daily activities.*

*** Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include eye, dental, or routine physical exams.*

2) Describe the medical facts which support your certification.

Call 888.367.4624 E-mail: FMLACenter@compsych.com www.fmlasource.com

Healthcare Provider please return form directly to:

FMLASource, 455 N. Cityfront Plaza Drive, Chicago, IL 60611-5322 or confidential fax: 877-309-0218

Name: _____

FMLA ID Number: _____

Step 2: Type of Leave/Duration of Leave

1) Healthcare Provider must check the appropriate type of leave and estimate the duration of the leave.

Continuous:

I certify that the employee will be unable to perform work of any kind due to this condition during this timeframe.

Probable duration of leave:

Specific Begin Date _____
MM/DD/YY

Specific End Date _____
MM/DD/YY

Reduced Hours:

I certify that the employee is only able to work a reduced schedule due to this condition.

Probable duration of leave:

Specific Begin Date _____
MM/DD/YY

Specific End Date _____
MM/DD/YY

Reduced hours schedule:

_____ Hrs/per day _____ Hrs/per week _____ Days/per week

Intermittent:

I certify that the employee is able to work, but it will be necessary to be absent from work intermittently (occasional, episodic).

Probable duration of leave:

Specific Begin Date _____
MM/DD/YY

Specific End Date _____
MM/DD/YY

Frequency of episodes of incapacity:

Maximum hours absent per week _____ and/or Maximum days absent per month _____ and/or

Maximum days absent per year _____ and/or

Treatments/Interval of treatments (if applicable to condition):

Number of treatments _____

Frequency of treatments _____

2) Please indicate if this condition is permanent or lifelong:

YES

No

Step 3: Signature

Healthcare Provider must sign and return form directly to FMLASource.

Signature _____ Date _____ Date Revised _____ Initial _____

Print Name _____ Phone _____ Fax _____

Type of Practice _____

Street Address _____ City _____ State _____ Zip _____

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