

## Medical Certification for FMLA – Family Member

The Healthcare Provider must complete and return this form directly to FMLASource by \_\_\_\_\_

Employee Name: \_\_\_\_\_ FMLA ID Number: \_\_\_\_\_  
Company Name: \_\_\_\_\_ Patient Name: \_\_\_\_\_

### Step 1: Reason for Leave

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

#### Pregnancy



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

- Incapacitated\* due to pregnancy
- Receiving prenatal care

Expected delivery date: \_\_\_\_\_

#### Medical Condition



I certify that the above patient 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 patient 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.

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Call 888.367.4624 E-mail: [FMLACenter@compsych.com](mailto:FMLACenter@compsych.com) [www.fmlasource.com](http://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 above employee is needed to care for, or provide beneficial psychological comfort to spouse, child (who is under 18 or incapable of self-care because of disability), or parent, and the employee will be unable to perform work of any kind 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 above employee needs reduced work hours to care for, or provide beneficial psychological comfort to spouse, child (who is under 18 or incapable of self-care because of disability), or parent.

Probable duration of leave:

Specific Begin Date \_\_\_\_\_  
MM/DD/YY

Specific End Date \_\_\_\_\_  
MM/DD/YY

Reduced hours schedule:

\_\_\_\_\_ Hrs worked/per day    \_\_\_\_\_ Hrs worked/per week    \_\_\_\_\_ Days worked/per week

**Intermittent:**

I certify that the above employee needs to occasionally or episodically be absent from work to care for, or provide beneficial psychological comfort to spouse, child (who is under 18 or incapable of self-care because of disability), or parent.

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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