FAMILY MEDICAL LEAVE ACT (FMLA)
Certification of Health Care Provider for
EMPLOYEE'S SERIOUS HEALTH CONDITION

SECTION I:

City of Tacoma, Human Resources
747 Market St #1420
Tacoma, WA 98402
Phone: 253-591-5452 **Fax**: 253-591-5451

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305 (b).

Employee Name: _____ Employee #: _____

Employee Signature: _____ Date: _____

For further information regarding "Employee Rights & Responsibilities under the FMLA" at the Department of Labor's website at http://www.dol.gov/esa/whd/regs/compliance/posters/fmlaen.pdf

AFTER YOUR HEALTH CARE PROVIDER COMPLETES AND SIGNS SECTION III, RETURN THIS COMPLETED FORM TO:

City of Tacoma
Human Resources Department
747 Market St. #1420
Tacoma, WA 98402
FAX: 253-591-5451

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. 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. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page. **PLEASE RETURN THE COMPLETED AND SIGNED FORM TO THE PATIENT.**

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Patient's Name: _____

Medical Provider's Name: _____

Type of practice / Medical specialty: _____

Address: _____

Telephone _____ Fax # _____

1. **Provide condition and describe relevant medical facts** related to the condition for which the employee seeks medical leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

2. Approximate date condition commenced: _____

Probable duration of condition: _____

_____

Mark below as applicable:
Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
_____No _____ Yes If so, dates of admission:

_____

Date(s) you treated the patient for condition:

_____

Will the patient need to have treatment visits **at least twice per year** due to the condition? _____No _____ Yes

Was medication, other than over-the-counter medication, prescribed? _____No _____Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? _____No _____Yes If so, state the nature of such treatments and expected duration of treatment:

_____

_____

3. Is the medical condition pregnancy? _____No _____Yes - If so, expected delivery date: _____

4. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee able to perform **any** of his/her job functions due to the condition: _____ No _____Yes

If no, what is the duration? _____

Please identify the job functions the employee is unable to perform: _____

_____

_____

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? _____No ____Yes

If so, provide the **beginning and ending dates** the employee will be off work on a continuous basis:

_____

_____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? _____No _____Yes

If so, are the treatments or the reduced number of hours of work medically necessary? _____No _____Yes

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

_____

_____

If the employee can work a reduced work schedule ; how many hours per day and/or days per week can the employee work?

_____

_____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? _____No _____ Yes

Is it medically necessary for the employee to be absent from work during the flare-ups? _____ No _____Yes
If yes, please explain:

_____

_____

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have (e.g., 1 episode every 3 months lasting 1-2 days): **PLEASE BE SPECIFIC**

Frequency: _____ # times per -- **week or month** (circle one)

Duration: _____ # **of hours or # of day(s)** per episode (circle one)

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____
Name of Health Care Provider (Please Print)

_____ _____
Signature of Health Care Provider **Date**

City of Tacoma
Human Resources Department
747 Market St. #1420
Tacoma, WA 98402
Fax 253-591-5451

To request this information in an alternative format, please contact Human Resources at 253-591-5452 or Washington Relay 711