FAMILY AND MEDICAL LEAVE ACT (FMLA)
Certification of Health Care Provider for
***FAMILY MEMBER'S* Serious Health Condition**

SECTION I: EMPLOYER

City of Tacoma
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 family member or his/her 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 to care for a covered family member with a 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. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Employee name: _____
First Middle Initial Last

Employee #: _____

Name of family member for whom you will provide care:_____

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____

_____ _____
Employee's 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

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the 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 below. 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 patient needs leave. Page 3 provides space for additional information, should you need it. **Please be sure to sign the form on the last page.**

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.

Please note that information about the health condition of your patient may be provided as needed to complete the certification request.

PATIENT'S NAME: _____

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone Number _____ Fax Number _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

____ No ____ Yes If "Yes" dates of admission: _____

Date(s) you treated the patient for condition: _____

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

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

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

_____

2. Is the medical condition pregnancy? _____No _____Yes If "Yes" expected delivery date: _____

3. Describe other relevant medical condition and facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

_____

PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care **by the employee** seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? _____No _____Yes

Estimate the beginning and ending dates for the period of incapacity: _____

During this time, will the patient need care? _____No _____ Yes

Explain the care needed by the patient why such care is medically necessary:

_____

_____

_____

_____

5. Will the patient require follow-up treatments, including any time for recovery? _____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:

_____

Explain the care needed for the patient ***by the employee*** requesting FMLA and why such care is medically necessary:

_____

_____

6. Will the patient require care ***by the employee*** on an intermittent or reduced schedule basis, including any time for recovery? _____No _____Yes

Estimate the hours the patient needs care on an intermittent basis, ***by the employee***, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? _____No _____Yes

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) ***where the employee will need time off to care for the patient:***

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or _____ day(s) per episode

Does the patient need care during these flare-ups? _____ No _____Yes

Please explain the care needed by the patient, by the employee, and why such care is medically necessary:

_____

_____

_____

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____ _____

Name of Health Care Provider (Print) Type of Practice

_____ _____

Signature of Health Care Provider Date

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