Certification of Health Care Provider for Employee’s Serious Health Condition
(Family and Medical Leave Act)

SECTION I: For Completion by HARVARD UNIVERSITY SCHOOL/DEPARTMENT

HR contact: Antonia Gonzalez: Ph 617-432-1024, Fax: 617-432-5005, Email: Leave_ofabsence@hms.harvard.edu

Employee’s job title: _____________________________ Regular work schedule: _____________________________

Employee’s essential job functions: _________________________________________________________________

Check if job description is attached: _____

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. When requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. Failure to provide a complete and sufficient medical certification within 15 calendar days may result in a denial of your FMLA request.

Your name: _________________________________________________________________________________

First    Middle     Last

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 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 employee is seeking leave. Do not provide information about genetic tests, genetic services, or the manifestation of disease or disorder in the employee’s family members. Page 3 provides space for additional information, should you find it necessary. Please be sure to sign the form on the last page.

Provider’s name and business address: _____________________________________________________________

Type of practice / Medical specialty: _______________________________________________________________

Telephone: (_______)___________________________ Fax: (_______)______________________________

PART A: MEDICAL FACTS

1. 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: ________________________________

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 so, state the nature of such treatments and expected duration of treatment:
   ________________________________________________________________________________
   ________________________________________________________________________________

2. Is the medical condition pregnancy? ____ No ____ Yes
   If so, expected delivery date: __________________________

3. Use the information provided by the employer in Section I to answer this question. If a list of the employee’s essential functions or a job description is not included, answer these questions based upon the employee’s own description of his/her job functions.

   Is the employee unable to perform any of his/her job functions due to the condition? ____ No ____ Yes

   If so, identify the job functions the employee is unable to perform: ________________________________
   ________________________________________________________________________________

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):
   ________________________________________________________________________________
   ________________________________________________________________________________
   ________________________________________________________________________________
   ________________________________________________________________________________
   ________________________________________________________________________________
   ________________________________________________________________________________
   ________________________________________________________________________________
   ________________________________________________________________________________

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, estimate the beginning and ending dates for the period of incapacity: __________________________
6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of his/her 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:

________________________________________________________________________________________________________________________

Estimate the part-time or reduced work schedule the employee needs, if any:

______ hour(s) per day; ________ days per week from ______________ through ____________________

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 so, explain: ____________________________________________________________

_________________________________________________________________________________________

Based upon the employee’s medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the employee may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

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

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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

Signature of Health Care Provider _______________________________________________________________________________________

State License Number: ________________________________ Date ______________________________

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