Certification of Health Care Provider for Family Member’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.

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. 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:________________________________________________________________________________

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 Signature       Date

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. Do not provide information about genetic tests or genetic services. 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. Describe other relevant medical 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 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: ________________________

   During this time, will the patient need care? ____ No ____ Yes

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

   _____________________________________________________________________________________

   _____________________________________________________________________________________

   _____________________________________________________________________________________

   _____________________________________________________________________________________

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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 by the patient, and why such care is medically necessary:

   __________________________________________________________

6. Will the patient require care on an intermittent basis, including any time for recovery? ____ No ____ Yes

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

   ______ hour(s) per day; ______ days per week from ________________ through ________________

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

   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

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 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

   Does the patient need care during these flare-ups? ____ No ____ Yes

   If so, explain the care needed by the patient, and why such care is medically necessary:

   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

ADBITIONIAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

Signature of Health Care Provider ___________________________ Date ________________

State License Number: ___________________________