



MEDICAL LOA CERTIFICATION

Human Resources

NON-FMLA (Family Member)

Family Member's Certification of Serious Health Condition

Health Care Provider Form

This Leave of Absence specifies as a Medical LOA for the Family member and in order to determine whether leave is covered under the Medical LOA Policy, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient.

SECTION I: 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. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. The completed form must be returned to Human Resources within 15 calendar days from receipt of this form.

Employee Name (Please Print)

First

Middle

Last

Employee #

Name of family member for whom you will provide care: (Please Print) First Middle Last

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 II: 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.

Provider’s name and business address:

Type of practice / Medical specialty:

Telephone: ()	Fax: ()
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PART A: MEDICAL FACTS

1. Approximate date condition commenced:

Diagnosis or condition family member treated for:

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

6. Will the patient require care 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, 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 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 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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Signature of Health Care Provider: _____ Date: _____

Return to Alberta Graham, Human Resources
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