ADMINISTRATIVE SERVICES HUMAN RESOURCES

# FAMILY AND MEDICAL LEAVE ACT (FMLA) MEDICAL CERTIFICATION - EMPLOYEE

## SECTION 1: To be completed by the EMPLOYEE:

Employee's Name: _____

Job Title: _____ Work schedule (days/hours): _____

If Job Description provided by HR Rep, is it attached? ❑ YES (required for serious health conditions)

**Date due in Human Resources: (refer to your FMLA Leave request form)** _____

I authorize my health care provider to provide the information on this form for the purpose of determining if I qualify for an FMLA leave and for a Whatcom County Human Resources professional to contact my health care provider to authenticate and/or clarify information, if needed. I understand if I do not provide a complete and sufficient medical certification, my FMLA leave request could be delayed or denied.

Employee's Signature: _____ Date: _____

*An employee who fraudulently obtains FMLA leave will be subject to disciplinary action, up to and including termination.*

## SECTION 2: To be completed by the HEALTH CARE PROVIDER:

***Instructions**: Your patient has requested leave under FMLA. Answer fully and completely ALL applicable parts. Give your **best estimate** based on your medical knowledge and experience. "Unknown" or "indeterminate" is not sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave and do not provide any genetic information. Failure to provide sufficient information may cause the employee's FMLA request to be delayed or denied.*

### Part A: Medical Facts

Approximate date the condition began: _____ Probable duration: _____

**Mark below as applicable:**

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

   ❑ Yes ❑ No If yes, date(s) of admission: _____

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

3. Will the patient need to have treatment visits at least twice per year due to the condition? ❑ Yes ❑ No

4. Was medication, other than over-the-counter medication, prescribed? ❑ Yes ❑ No

5. Was the patient referred to other health care provider(s) for evaluation or treatment? ❑ Yes ❑ No

   If yes, state the nature of such treatments, expected duration of treatment, and the name of other medical provider(s): _____

   _____

6. Using the information provided by the employee in Section 1, is the employee **unable** to perform any of his/her essential job duties due to the condition? ❑ Yes ❑ No

   If yes, identify the job duties the employee is **unable** to perform: _____

   _____

7. Describe relevant facts, if any, such as symptoms, diagnosis, or any regimen of continuing treatment, related to the condition for which the employee seeks leave: _____

   _____

**Part B: Amount of Leave Needed**

1. 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?

   *("**Incapacity**", for purposes of FMLA, is defined as the inability to work, attend school, or perform other regular daily activities due to a serious health condition, treatment therefore, or recovery therefrom)*

   ❑ Yes ❑ No

   If yes, estimate the continuous period of incapacity. From: _____(date) to _____(date)

2. Will it be **medically necessary** for the employee to have follow-up treatments? ❑ Yes ❑ No

   If yes, estimate the treatment schedule, times needed for treatments, any scheduled appointments, and recovery periods, if necessary: _____

   _____

3. Is it **medically necessary** for the employee to work part-time or a reduced work schedule?

   ❑ Yes ❑ No

   If yes, please estimate: _____ hour(s) per day off work; _____ day(s) per week off work

   From: _____(date) to: _____(date)

4. Will the condition cause episodic flare-ups which prevent the employee from performing his/her job duties?

   ❑ Yes ❑ No

   If yes, is it **medically necessary** for the employee to be absent from work during flare-ups?

   ❑ Yes ❑ No 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 incapacity that the patient may have:

   **Frequency:** _____ # times per ❑ week or ❑ month

   **For:** _____ # hours or _____ # day(s) per episode

   **From:** _____ (date) to _____ (date)

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|---|---|
| **Name of Health Care Provider** | **Signature of Health Care Provider** |
| **Address** | **Phone** |
| **Type of Practice/Specialty** | **Date** |

**FAX OR MAIL COMPLETED FORM TO:**
**Whatcom County Human Resources ● 311 Grand Avenue, Suite 107 ● Bellingham, WA 98225**
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