Certification of Health Care Provider for Family Member's Serious Health Condition under the Family and Medical Leave Act

U.S. Department of Labor Wage and Hour Division



DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.

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The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave to care for a family member with a serious health condition to submit a medical certification issued by the family member's health care provider. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I - EMPLOYER

(1) Employee name:

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Additionally, you may not request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees or employees' family members created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

	First	Middle	Last	
(2) Employer name:			Date:	_ (mm/dd/yyyy)
			(List date certification requested	(k
(3) The medical certifica	tion must be returned by			. (mm/dd/yyyy)
(Must allow at least 15	calendar days from the date requested,	unless it is not feasible despite th	ne employee's diligent, good faith efforts.)	
SECTION II - EMPLO	YEE			
allows an employer to re the serious health condi the FMLA protections. 2 employer within the tin	equire that you submit a timely, comition of your family member. If reques 9 U.S.C. §§ 2613, 2614(c)(3). You	plete, and sufficient medical c ested by your employer, your are responsible for making be at least 15 calendar days	your family member's health care provide pertification to support a request for FMLA response is required to obtain or retain a sure the medical certification is provided by C.F.R. §§ 825.305-825.306. Failure quest. 29 C.F.R. § 825.313.	A leave due to the benefit of vided to your
(1) Name of the family m	nember for whom you will provide ca	re:		
(2) Select the relationshi	p of the family member to you. The f	amily member is your:		
Spouse	☐ Parent	Child, under a	age 18	
Child, age 1	8 or older and incapable of self-care	because of a mental or physic	cal disability	

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including in a common law marriage or same-sex marriage. The terms "child" and "parent" include in loco parentis relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for an individual who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a child for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.

Employee Name:				
(3) Briefly describe the care you will provide	de to your family membe	er: (Check all that apply	')	
Assistance with basic medical	al, hygienic, nutritional,	or safety needs	Transportation	
Physical Care Ps	sychological Comfort	Other:		
(4) Give your best estimate of the amoun	t of leave needed to pro	ovide the care described:		
(5) If a reduced work schedule is necess you are able to work. From(hours per day)	(mm/dd/yyy	described, give your bes		
Employee Signature			Date	(mm/dd/yyyy
SECTION III - HEALTH CARE PROV	IDER			
Please provide your contact information, has requested leave under the FMLA to complete, and sufficient medical certificat For FMLA purposes, a "serious health or care or continuing treatment by a health or see the chart at the end of the form. You also may, but are not required to, pure treatment such as the use of specialized information about the patient's serious health.	care for your patient. cion to support a reques condition" means an illu- care provider. For more provide other appropriat d equipment. Please no	The FMLA allows an enst for FMLA leave to carsess, injury, impairment, information about the deate medical facts including ote that some state or lo	mployer to require that the re for a family member with or physical or mental condefinitions of a serious healthing symptoms, diagnosis, or ocal laws may not allow displacements.	employee submit a timely a serious health condition lition that involves inpatien a condition under the FMLA any regimen of continuing
Health Care Provider's name: (Print)				
Health Care Provider's business address:				
Type of practice / Medical specialty:				
Telephone:	Fax:	E-mail:		
PART A: Medical Information				
Limit your response to the medical cond based upon your medical knowledge, exinformation about the amount of leave regular daily activities due to the condition tests, as defined in 29 C.F.R. § 1635.3(f) the employee's family members, 29 C.F.R.	regrience, and examination needed. Note: For FMI note: F	ation of the patient. Aft o ILA purposes, "incapacity dition, or recovery from the state of the state of the patients of the patients.	er completing Part A, co "means the inability to wor he condition. Do not provide	mplete Part B to provide k, attend school, or perform e information about genetic
(1) Patient's Name:				
(2) State the approximate date the condition	on started or will start:			(mm/dd/yyyy)
(3) Provide your best estimate of how lon	g the condition lasted o	or will last:		
(4) For FMLA to apply, care of the patient assistance with basic medical, hygienic, n				

Employee Name:								
(5) Check the box(es) for the questions below, as applicable. For all box	(es) checked, the amount of leave ne	eeded must be provided in Part B.						
☐ Inpatient Care: The patient (☐ has been / ☐ is expected to hospice, or residential medical care facility on the following date	• •							
Incapacity plus Treatment: (e.g. outpatient surgery, strep throa								
Due to the condition, the patient (has been / is expect	ed to be) incapacitated for more thar	n three						
consecutive, full calendar days from: (mm/	dd/yyyy) to(mm/d	dd/yyyy).						
The patient (was / will be) seen on the following date(s):							
The condition (has / has not) also resulted in a cours health care provider (e.g. prescription medication (other than over								
Pregnancy: The condition is pregnancy. List the expected del	livery date: (mm/dd/yyyy).						
Chronic Conditions: (e.g. asthma, migraine headaches) Due to treatment visits at least twice per year.	the condition, it is medically necessar	ary for the patient to have						
Permanent or Long Term Conditions: (e.g. Alzheimer's, termin or long term and requires the continuing supervision of a health								
Conditions requiring Multiple Treatments: (e.g. chemotherapy necessary for the patient to receive multiple treatments.	Conditions requiring Multiple Treatments: (e.g. chemotherapy treatments, restorative surgery) Due to the condition, it is medically necessary for the patient to receive multiple treatments.							
None of the above: If none of the above condition(s) were check needed. Go to page 4 to sign and date the form.	ced, (i.e., inpatient care, pregnancy) r	no additional information is						
6) If needed, briefly describe other appropriate medical facts related to to for nebulizer, dialysis)	the condition(s) for which the employe	ee seeks FMLA leave. (e.g., use						
PART B: Amount of Leave Needed								
For the medical condition(s) checked in Part A, complete all that apply. condition, treatment, etc. Your answer should be your best estimate be patient. Be as specific as you can; terms such as "lifetime," "unknown," protections of the FMLA apply.	ased upon your medical knowledge,	experience, and examination of the						
7) Due to the condition, the patient (had / will have) planned psychotherapy, prenatal appointments) on the following date(s):	• • •	, , ,						
8) Due to the condition, the patient (was / will be) referred to	other health care provider(s) for e	evaluation or treatment(s).						
State the nature of such treatments: (e.g. cardiologist, physical therapy)								
Provide your best estimate of the beginning dateor the treatment(s).	(mm/dd/yyyy) and end date	(mm/dd/yyyy).						
Provide your best estimate of the duration of the treatment(s), including	any period(s) of recovery (e.g. 3 day	rs/week)						

Employee Name:	
(9) Due to the condition, the patient (was / will be) incapacitated for a continuous period of time, including any time	
for treatment(s) and/or recovery.	
Provide your best estimate of the beginning date (mm/dd/yyyy) and end date (mm/dd/yyyy). for the period of incapacity.	
(10) Due to the condition, it (was / is / will be) medically necessary for the employee to be absent from work to	
provide care for the patient on an intermittent basis (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide y best estimate of how often (frequency) and how long (duration) the episodes of incapacity will likely last.	our/
Over the next 6 months, episodes of incapacity are estimated to occur times p	er
(day week month) and are likely to last approximately (hours days) per epis	sode.
Signature of Health Care Provider Date: (mm/dd	l/yyyy)
Definitions of a Serious Health Condition (See 29 C.F.R. §§ 825.113115)	
Inpatient Care	
 An overnight stay in a hospital, hospice, or residential medical care facility. Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay. 	
Continuing Treatment by a Health Care Provider (any one or more of the following)	
Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, where the supervision of the health care provider. For example, the health care might prescribe a course of prescription medication or therapy requiring special equipment.	hich
Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.	
Chronic Conditions : Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.	Э
Permanent or Long-term Conditions : A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.	
Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would	_

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 15 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.