



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)

Name of Health Care Provider

Signature of Health Care Provider

Address

Phone

Type of Practice/Specialty

Date

FAX OR MAIL COMPLETED FORM TO:

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