Certification of Health Care Provider for Employee's Family Member's Serious Health Condition (Family and Medical Leave Act & New Jersey Family Leave Act)

SECTION I: For Completion by the EMPLOYEE			
INSTRUCTIONS to the EMPLOYEE: Please complete Section I before giving this form to your family member or his/her medical provider. You are required to submit a timely, complete, and sufficient medical certification to support a request for FMLA/NJFLA leave to care for a covered family member with a serious health condition. Your response is required to obtain or retain the benefit of FMLA/NJFLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA/NJFLA request. **You have 15 calendar days to return this form to your employer**.			
YOUR OWN:			
FAMILY MEMBER:			
Relationship of family member to you:			
If family member is your son or daughter, date of birth:			
Describe the care you will provide to your family member and estimate the leave needed to provide care:			
Employee Signature:		Date:	

SECTION II: For Completion by the HEALTH CARE PROVIDER	
INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA/NJFLA 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/NJFLA coverage. Limit your responses to the condition for which the patient needs care. Do not provide information about genetic tests, as defined in 29 CFR§1635.3(f) or genetic services, as defined in 29 CFR§1635.3(e). The last page provides space for additional information, should you need it. Please be sure to sign the form on the last page.	
Provider's Name:	
Provider's Business Address:	
Type of Practice/Medical Specialty:	
Phone #:	Fax #:

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PART A: MEDICAL FACTS (For Completion by the HEALTH CARE PROVIDER)

1. Approximate date condition commenced:	Probable duration of condition:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ☐ No ☐ Yes

If yes, date(s) of admission:

Date(s) you treated patient for condition:

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

Was medication, other than over-the-counter medication, prescribed? ☐ No ☐ Yes

Was 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 employee seeks leave (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 (For Completion by the HEALTH CARE PROVIDER)

INSTRUCTIONS to the HEALTH CARE PROVIDER: 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 start and end dates for the period of incapacity: Start: End:

During this time, will the patient need care by the employee seeking leave? ☐ No ☐ Yes
If so, 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

If so, 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 from the employee seeking leave, 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

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

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

Hour(s) per day: # Days per week:

From: Through:

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	
Explain the care needed by the patient from the employee seeking leave and why such care is medically necessary:	
ADDITIONAL INFORMATION: (Identify question number with your additional answer.)	
Signature of Health Care Provider:	Date: