Certification of Health Care Provider
for Employee's Serious Health Condition
Family and Medical Leave Act

SECTION I: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section I before giving this form to your medical provider. You are required to submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. 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. **You have 15 calendar days to return this form**. By signing this form, you consent to allow an authorized representative of Rutgers to contact your health care provider to clarify information provided on this form.

First Name:	Middle Initial:	Last Name:

Job Title:

Regular Work Schedule: From: To: ☐ S ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S

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. Do not provide information about genetic tests, as defined in 29 CFR § 1635.3(f), genetic services, as defined in 29 CFR § 1635.3(e), or the manifestation of a disease or disorder in the employee’s family member, 29 CFR § 1635.3(b). 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, dates of admission:

Dates 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. If a list of the employee's essential functions or a job description are not provided, please answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition? ☐ No ☐ Yes

If so, identify the job functions the employee is unable to perform:

4. 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 LEAVE NEEDED (For Completion by the HEALTH CARE PROVIDER)

5. 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? ☐ No ☐ Yes

If so, estimate the start and end dates for the period of incapacity: Start: End:

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ☐ No ☐ Yes

If so, are the treatments or the reduced number of hours of work medically necessary? ☐ 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:	Estimate the part-time or reduced work schedule the employee needs, if any: # Hour(s) per day: # Days per week: From: Through:

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: