Medical Certification for FMLA - Employee

Your Healthcare Provider/Case Worker must complete and return this form to FMLASource

Confidential fax: 877-309-0218 or Mail: FMLASource, 455 N. Cityfront Plaza Drive, Chicago, IL 60611-5322

Name: ________________________________  FMLA Leave Request Number: __________________
Company Name: ________________________________

Step 1: Reason for Leave

I, (Health Care Provider/Case Worker), certify the employee’s medical condition meets one or more of the following conditions (please check any that apply):

Pregnancy:
- Incapacitated* due to pregnancy
- Receiving prenatal care

Medical Condition:
- Incapacitated* for more than three consecutive days AND received treatment** at least 2 times for this condition within 30 days of incapacitation.
- Incapacitated* for more than three consecutive days AND received treatment** for this condition AND prescribed a regimen of continuing treatment** (i.e. therapy, Rx).
- Incapacitated* by or out of work to receive treatment** for a chronic serious health condition which requires:
  - At least 2 visits for treatment per year
  - Continues over extended period of time and
  - Causes episodic or continuing incapacity.*
- Incapacitated* by a permanent/long-term condition for which patient is undergoing continuing treatment** (i.e. Alzheimer's, severe stroke).

New Child:
- Out of work to care for or bond with a Newborn Child, or Child Newly Placed for Adoption or Foster Care

Hospital Stay:
- An inpatient in a hospital, hospice or residential medical care facility.
- Out of work to receive treatment** for a condition connected to a previous inpatient stay.
- Recovering from inpatient stay and incapacitated*

If any of the above apply, please specify dates of admission:

______/______/______ ➔  ______/______/______

*Incapacity is defined as inability to work or perform regular daily activities.
**Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition.
Treatment does not include eye, dental, or routine physical exams. Treatment does not include voluntary Cosmetic Procedures.

Please indicate the dates you have treated the employee for this condition:

______/______/______ ➔  ______/______/______

Please list any facts (which can include symptoms, diagnosis, prescription medication or other treatments) relevant to the condition(s):

We request that you do not provide us with any genetic information when responding to this request for medical information.
Please list any facts (which can include symptoms, diagnosis, prescription medication or other treatments) relevant to the condition(s):

If the employee works in the state of California, please do not provide a diagnosis.

I, (Health Care Provider/Case Worker) certify that the employee’s medical condition does not meet at least one of the above listed conditions:

☐ None of the above conditions apply

Call: 877-3PG-FMLA  Email: FMLAcenter@FMLASource.com  Visit: www.FMLASource.com  FAX: 877-309-0218

Healthcare Provider please return form directly to:
FMLASource, 455 N. Cityfront Plaza Drive, Chicago, IL 60611-5322 or confidential fax: 877-309-0218

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Continuous:

I certify that the above employee is/was/will be incapacitated for a single continuous period due to his/her medical condition including time for treatment and recovery:

(A) Begin date: _____/_____/_____   End date: _____/_____/_____  
(Estimate dates if unknown)

Reduced Schedule:

I certify that the above employee will need to work the following part-time/reduced-hours schedule due to the condition:

(A) Begin date: _____/_____/_____   End date: _____/_____/_____  
(Estimate dates if unknown)

(B) If the schedule is fixed, please indicate hours/days per week the employee can work:

|------|------|------|------|------|------|------|

(C) If the schedule varies weekly, please indicate the number of hours per day and the number of days per week the employee is able to work:

_____ Hours/Day   _____ Days/Week

Intermittent/Episodic:

I certify that it is medically necessary for the employee to miss work for episodic absences due to their condition as follows:

(A) Begin date: _____/_____/_____   End date: _____/_____/_____  
(Estimate dates if unknown)

(B) Number of treatments/appointments scheduled:

- Frequency = _____ # per _____ week(s) or _____ month(s) or _____ year
- Duration = _____ # hour(s) per treatment(s)

Please ESTIMATE treatment schedule (if any) including pre-scheduled appointments, the time required for each appointment (including any recovery period):

(C) Will the condition cause episodic flare-ups that will prevent the employee from attending work or performing their job duties?

☐ Yes  ☐ No

(D) Based on the patients medical history & your knowledge of the medical condition, please indicate the frequency AND duration of episodes of incapacitation (e.g. 3 times per 2 months lasting 1-2 days):  
- Frequency = _____ # time(s) per _____ week(s) or _____ month(s)
- Duration = _____ # hour(s) or _____ days(s) per episode(s)