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

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. The employer must give the employee 15 calendar days to provide the medical certification required to support the FMLA application. If the employee fails to provide complete and sufficient medical certification, the FMLA leave request may be denied. **Completed forms should be sent via email to DisabilityandLeaves@fcps.edu or via fax 571-423-5013.** More information about FMLA may be found on the FCPS website (www.fcps.edu, search "FMLA").

SECTION I: For Completion by the EMPLOYEE

While this form is not required, it asks the health care provider for the information necessary for a complete and sufficient medical certification. Please complete this section before giving this form to your family member or your family member's health care provider.

1. Employee's name: _____
2. Employee ID: _____
3. Employer name and contact: Fairfax County Public Schools, Human Resources Department, Benefits, 571-423-3200
4. Name of the family member for whom you will provide care: _____
5. Select the relationship of the family member to you. The family member is your:
   - ☐ Spouse
   - ☐ Parent
   - ☐ Child, under age 18
   - ☐ Child, age 18 or older and incapable of self-care because of a mental or physical 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.*
6. Briefly describe the care you will provide to your family member: (Check all that apply)
   - ☐ Assistance with basic medical, hygienic, nutritional, or safety needs
   - ☐ Transportation
   - ☐ Physical Care
   - ☐ Psychological Comfort
   - ☐ Other: _____
7. Give your best estimate of the amount of leave needed to provide the care described:

   _____

   _____

   _____
8. If a reduced work schedule is necessary to provide the care described, give your best estimate of the reduced schedule you are able to work.

   From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*, I am able to work

   _____*(hours per day)* _____*(days per week).*

Date Received by Disability and Leaves: _____

CONTINUED ON NEXT PAGE

Employee Name: _____

SECTION I: (continued)

Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees 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. The employer may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employees are not required to provide medical certification if requesting FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care. Legal Citations 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305;29 C.F.R. § 825.313 and C.F.R. § 825.600-604. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305.

Employee Signature _____ **Date** _____ *(mm/dd/yyyy)*

SECTION II: For Completion by the HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient's family member has requested leave under the FMLA. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to a family member's serious health condition. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves inpatient care or continuing treatment by a health care provider. For more information about the definitions of a serious health condition under the FMLA, see the chart on page 4.

Health Care Provider's Name: _____

Health Care Provider's Business Address: _____

Type of practice or medical speciality: _____

Telephone: _____ Fax: _____ Email: _____

PART A: MEDICAL INFORMATION

Limit your response to the medical condition(s) for which the employee is seeking FMLA leave. Your answers should be your best estimate based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition.

1. Patient's name: _____
2. Approximate date condition started/will start: _____ *(mm/dd/yyyy)*
3. Provide your best estimate of how long the condition lasted or will last: _____
4. For FMLA to apply, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient (e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort).

_____
_____
_____
_____
_____

Employee Name: _____

SECTION II: (continued)

5. Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

   ☐ **Inpatient Care:** The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____

   ☐ **Incapacity plus Treatment:** *(e.g. outpatient surgery, strep throat)*
   Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for more than three consecutive, full calendar days from _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy).*

   The patient (☐ was / ☐ will be) seen on the following date(s): _____

   The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider (e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment).

   ☐ **Pregnancy:** The condition is pregnancy. List the expected delivery date: _____ *(mm/dd/yyyy).*

   ☐ **Chronic Conditions:** *(e.g. asthma, migraine headaches)*
   Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

   ☐ **Permanent or Long Term Conditions:** *(e.g. Alzheimer's, terminal stages of cancer)*
   Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

   ☐ **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 checked (i.e., inpatient care, pregnancy), no additional information is needed. Go to page 4 to sign and date the form.

6. If needed, briefly describe other appropriate medical facts related to the condition(s) of the patient's treatment (e.g., use of nebulizer, dialysis): _____

_____

Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

PART B: AMOUNT OF LEAVE NEEDED

For the medical condition(s) checked in Part A, complete all that apply. 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.

7. Due to the condition, the patient (☐ had / ☐ will have) planned medical treatment(s) (scheduled medical visits) (e.g. 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 evaluation or treatment(s).

   State the nature of such treatments: (e.g. cardiologist, physical therapy) _____

   Provide your best estimate of the beginning date _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the treatment(s).

   Provide your best estimate of the duration of the treatment(s), including any period(s) of recovery (e.g. 3 days/week):

   _____

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.

Employee Name: _____

SECTION II: (continued)

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 your best estimate of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

    Over the next 6 months, episodes of incapacity are estimated to occur _____ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ (☐ hours / ☐ days) per episode.

PART C: SIGNATURE

_____ _____

Signature of Health Care Provider **Date**

Definitions of a Serious Health Condition *(See 29 C.F.R. §§ 825.113-.115)*
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: • 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, • At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
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.
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 likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.