

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

U.S. Department of Labor

Wage and Hour Division



DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT

OMB Control Number: 1235-0003

Expires: 8/31/2021

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. 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.

Employer name and contact: Auburn Montgomery Informational Technology Department.

Employee's job title: Senior Program Associate Regular work schedule: M-F 8a-5p

Employee's essential job functions: Help with administrative duties.

Check if job description is attached:

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: Allyson Carter
First Middle Last

SECTION III: 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 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). Please be sure to sign the form on the last page.

Provider's name and business address: Carol Stewart, CRNP 7461 East Drive Montgomery, AL 36117

Type of practice / Medical specialty: Student Health Services--Family Practice

Telephone: (334) 244-3281 Fax: (334) 244-3396

PART A: MEDICAL FACTS

1. Approximate date condition commenced: 11/26/2018

Probable duration of condition: _____

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

☒ No ☐ Yes. If so, dates of admission: _____

Date(s) you treated the patient for condition: _____

11/26/18, 12/5/18, 1/11/19, 3/5/19 plus several phone consults.

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 the 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. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, 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:

Patient is suffering from crippling depression and adjustment reaction after her mothers recent death. She is not able to function in her job at present.

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):

I have been treating Allyson since 11/26/18 for depression and anxiety. She was the primary caregiver of her mother as she was dying from metastatic cancer. She has had a very difficulty time dealing with the illness and impending death of her mother. Her mother passed away about two weeks ago. Since then, Allyson has become responsible for her mothers estate and two younger brothers. She has become overwhelmed and is not coping well in life. She cries frequently and has required more medication to help her cope. I Will continue to follow and treat her as she adjusts over the next time period.

PART B: AMOUNT OF LEAVE NEEDED

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 beginning and ending dates for the period of incapacity: 3/5/19 thru 3/20/19

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:

Treatment will be ongoing and will continue after she has returned to work

Estimate the part-time or reduced work schedule the employee needs, if any:

N/A hour(s) per day; 0 days per week from N/A through N/A

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.

**AUBURN UNIVERSITY MONTGOMERY
STUDENT HEALTH CENTER
IRMA B. MOORE HALL RM. 102
P.O. BOX 244023
MONTGOMERY, AL 36124-4023**

Carol Stewart, CRNP
Signature of Health Care Provider

3-5-19
Date

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**