Family Member Health Certification - Form B

SECTION 1: TO BE COMPLETED BY EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: *Please complete Section 1 before giving this form to your family member or his/her 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 to care for a covered family member with a 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 to your employer. 29 C.F.R. § 825.305.*

_____ _____

Name (Last, First, MI) SS# (Last 4 Digits)

_____

Home Address (Street, City, State, Zip)

_____ _____

Patient's Name (Last, First, MI) Date of Birth

To qualify under the FMLA, if you are taking leave to care for your child, s/he must be under the age of 18. A child over age 18 may qualify if s/he has a disability as defined by the Americans with Disabilities Act (ADA) at the time the leave is to commence, be incapable of self-care because of the disability, has a serious health condition and needs care because of the serious health condition.

Relationship to Employee : ☐ Spouse ☐Mother ☐ Father ☐ Son ☐ Daughter

Describe the care you will provide to your family member _____

_____

Estimate of leave needed to provide care _____

_____ _____/_____/_____

Employee Signature Date

SECTION 2: TO BE COMPLETED BY HEALTH CARE PROVIDER

The employee listed above has requested leave under the FMLA 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 coverage. Limit your responses to the condition for which the patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e).

Part A: Medical Facts

1. Approximate date the condition commenced ____/____/____

Probable duration of the condition _____
(# of weeks/months/days)

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

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

Dates you treated the 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 the patient referred to other health care providers(s) for evaluation or treatment? No ☐ Yes ☐
(e.g., physical therapist)

If so, state the nature of such treatments and expected duration of treatment: _____

_____

2. Is the medical condition pregnancy? No ☐ Yes ☐ If yes estimated due 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 *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 beginning and ending dates

Beginning Date _____/_____/_____ End Date _____/_____/_____

During this time will the patient need care? 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 ☐

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, and why such care is medically necessary _____

_____

6. Will the patient require care on an intermittent or reduced scheduled basis, including any time for recovery? No ☐ Yes ☐ If so, estimate the hours the patient needs care on an intermittent basis

_____ hour(s) per day; _____ days per week from: _____/_____/_____ through _____/_____/_____

Explain the care needed by the patient, and why such care is medically necessary _____

_____

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 _____ days(s) per episode

Does the patient need care during these flare-ups? No ☐ Yes ☐ If so, explain the care needed and why such care is medically necessary _____

_____

Provider's Signature

Providers Name: _____

Address: _____

Phone: _____

Signature: _____

Date: _____/_____/_____

Fax or mail completed form to:

UNH Human Resources

2 Leavitt Lane

Durham, NH 03824

Fax# 603-862-5159