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

SECTION I: For Completion by HARVARD UNIVERSITY SCHOOL/DEPARTMENT

HR contact: Antonia Gonzalez Ph: 617-432-1024, Fax: 617-432-5005.

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II 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. When requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. Failure to provide a complete and sufficient medical certification within 15 calendar days may result in a denial of your FMLA request.

Your name:					
	First	Middle		Last	
Name of family me	ember for whom you	will provide care:			
D 1 (' 1' CC			First	Middle	Last
Relationship of far	nily member to you:				
If family n	nember is your son o	r daughter, date of bir	th:		
Describe care you	will provide to your	family member and es	timate leave no	eeded to provide o	care:
			_		
Employee Signatur	re		Date		
SECTION III: F	or Completion by th	ne HEALTH CARE	PROVIDER		
INSTRUCTIONS	to the HEALTH C	ARE PROVIDER:	The employee	listed above has re	eauested leave under
		swer fully and comple			
		luration of a condition			
		vledge, experience, an			
		n," or "indeterminate" or which the patient no			
		es space for additiona			
	form on the last page			onoura you mua n	necessary. Trease
Provider's name ar	nd business address:				
Type of practice / l	Medical specialty:				

Telephone: (_____)______Fax: (_____)____

PART A: MEDICAL FACTS

1.	Approximate date condition commenced:						
	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?						
	NoYes If so, dates of admission: Date(s) you treated the patient for condition:						
Was medication, other than over-the-counter medication, prescribed? No Yes							
	Will the patient need to have treatment visits at least twice per year due to the condition? No Yes						
	Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? NoYes						
2.	Is the medical condition pregnancy? No Yes If so, expected delivery date:						
3.	Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):						
nee	RT B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's ed for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, ety, 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 for the period of incapacity:						
	During this time, will the patient need care? No Yes						
	Explain the care needed by the patient and why such care is medically necessary:						

	State License Number:				
Sig	gnature of Health Care Provider Date				
ΑI	DDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.				
	If so, explain the care needed by the patient, and why such care is medically necessary:				
	Does the patient need care during these flare-ups? No Yes				
	Duration: hours or day(s) per episode				
	Frequency: times per week(s) month(s)				
	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):				
7.	Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? No Yes				
	Explain the care needed by the patient, and why such care is medically necessary:				
	hour(s) per day; days per week from through				
J.	Estimate the hours the patient needs care on an intermittent basis, if any:				
6.	Will the patient require care on an intermittent basis, including any time for recovery? No Yes				
	Explain the care needed by the patient, and why such care is medically necessary:				
	Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:				
5.	Will the patient require follow-up treatments, including any time for recovery? No Yes				