SALT LAKE COUNTY

Human Resources

Family's Serious Health Condition

Certification of Health Care Provider

(Family and Medical Leave Act of 1993 as Amended)

SECTION I: To be completed by **Agency**

This form is confidential. Agency must maintain documents relating to medical certifications, recertifications or medical histories of employees created for FMLA as confidential medical records in a file separate from the personnel file.

Agency Contact Person and phone/email:

SECTION II: To be completed by **Employee**

You must submit this form to the Agency contact person listed above within 15 calendar days.

Your Name:
Last Name First Name Middle Name/Initial

Name of family member for whom you will provide care:
Last Name First Name Middle Name/Initial

Relationship of family member to you: If son or daughter, date of birth:

Describe care you will provide to your family member and estimate leave needed to provide care:

Employee Signature Date

SECTION III: To be completed by **Health Care Provider**

When completed, return form to the employee.

Provider's name and business address:

Type of Practice/Medical Specialty: Phone No.

PART A: MEDICAL FACTS OF PATIENT

1. Approximate date condition commenced:

Approximate duration:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ☐ Yes ☐ No

If yes, date(s) of admission:

Date(s) you treated the patient for condition:

Was medication, other than over-the-counter medication, prescribed? ☐ Yes ☐ No

Will the patient need to have treatment visits at least twice per year due to the condition? ☐ Yes ☐ No

Was the patient referred to other health care provider(s) for evaluation or treatment(e.g. physical therapist?) ☐ Yes ☐ No

If yes, state the nature and expected duration of treatments:

2. Is the medical condition pregnancy? ☐ Yes ☐ No

If yes, expected delivery date:

3. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (e.g. 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 your patient's need for care by the employee seeking leave which may include assistance with basic medical hygiene, 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, including time for treatment and recovery? ☐ Yes ☐ No

If yes, estimate the beginning and ending dates for period of incapacity:

During this time will the patient need care? ☐ Yes ☐ No

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? ☐ Yes ☐ No

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each including recovery:

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

6. Will the patient be incapacitated for a single continuous period of time, including time for treatment and recovery? ☐ Yes ☐ No

Estimate the hours the patient needs care on an intermittent basis, if any:

_____ hour(s) per day; _____ days per week

from _____ through _____

Explain the care needed by the patient for which the employee seeks leave 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? ☐ Yes ☐ No

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)

Explain the care needed by the patient for which the employee seeks leave and why such care is medically necessary:

ADDITIONAL INFORMATION

Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

Signature of Health Care Provider

Date