

City of Toppenish Certification of Health Care Provider for Employee's Serious Health Condition

(Family and Medical Leave Act)

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, re-certifications, 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.

Employer name and contact: City of Toppenish, Debbie Zabell, (509)865-1639 Employee's job title: **Regular work schedule: Employee's essential job functions:** 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. 20 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: Last Middle

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. Please be sure to sign the form on the last page. Unanswered or partial responses may result in your patient having to bring this form back for completion.

Provider's 1	name:						
Business ad	dress: _						
Type of practice / Medical specialty:							
Telephone:	()			_		 ,
FAX:	()			_		
PART A: M	IEDICA	L FACTS:					
Approximate	e date co	ndition com	menced:				
Probable du	ration of	condition: _					
care faci	patient a lity? []	admitted for No Yes.	If yes, dates o	of admission	:		dential medical
	atient ne		reatment visits				
Was medi	cation, o	ther than ov	er-the-counter	· medication	, prescribed	1?	□Yes
physical t	herapist)	?		, state the n	ature of su	ch treatmen	treatment (e.g., ats and expected
			nancy? No				
employe answer t Is the en	r fails to hese que nployee	provide a lestions based unable to pe	list of the em d upon the em erform any of	ployee's ess ployee's ow his/her job	sential func on description functions d	ctions or a j on of his/he lue to the co	question. If the job description, or job functions. Ondition:
seeks lea	ave (suc	h medical f		clude symp	toms, diag	nosis, or a	th the employee ny regimen of

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 yes, estimate the beginning and ending dates for the period of incapacity:
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 yes, 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:
	Estimate the part-time or reduced work schedule the employee needs, if any: hr(s) per day; days per week from through
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 yes, 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):
Ad	Iditional Information: Identify question number with your additional answer.
Sig	gnature of Health Care Provider Date