Employee Name:_____ **FMLA Claim #:** _____

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

Please complete Section I 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 benefits of FMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request.

SECTION I: For Completion by the EMPLOYEE

Your Name:_____
First Middle Last

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

Relationship of family member to you:_____

If family member is your son or daughter, date of birth:mm/dd/yy_____

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

_____

_____

_____

_____ mm/dd/yy _____
Employee Signature Date

SECTION II: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTHCARE 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. Page 2 provides for additional information, should you need it. Please be sure to sign the form on the last page.

NOTE TO ALL HEALTH CARE PROVIDERS: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic Information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Provider's name and business address:_____

Type of practice / Medical specialty:_____

Telephone: (___) _____ Fax: (___) _____

Part A: Medical Facts

1) Approximate date condition commenced:mm/dd/yy_____

Probable duration of condition:_____

Employee Name: _____ FMLA Claim #: _____

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
☐No ☐Yes If so, dates of admission:

For employees working in California only:

Was the patient formally admitted to a medical facility with the expectation that he or she would remain at least overnight and occupy a bed, even if it later developed that the patient could be discharged or transferred and did not spend the night?

☐No ☐Yes If so, dates of admission:

Date(s) 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 the medication, other than over-the-counter medication, prescribed? ☐No ☐Yes
Was the patient referred to the 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: mm/dd/yy

3) Describe other relevant medical facts, if any, related to the condition for which the patient needs care seeks leave (Such medical facts may include symptoms, diagnosis, or regimen of continuing treatment such as the use of specialized equipment). Note to California Physicians: You may not disclose your patient's underlying diagnosis without their consent.:

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, including any time for treatment and recovery? ☐No ☐Yes
Estimate the beginning and ending dates for the period of incapacity: mm/dd/yy mm/dd/yy
During this time, will the patient need care? ☐No ☐Yes
Explain the care needed by the patient and why such care is medically necessary:

Employee Name: _____ FMLA Claim #: _____

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 schedule basis, including any time for recovery? ☐No ☐Yes
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, and why such care is medically necessary:

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.

Employee Name: _____ FMLA Claim #: _____

Health Care Provider Signature

mm/dd/yy
Date

Please return to the employer's FMLA administrator at:

MetLife Disability
P.O. Box 14590
Lexington, Kentucky 40512
Fax: 1-800-230-9531