Employee Name: ____________________ FMLA Claim #: ____________________

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

Please complete Section I 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 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

SECTION II: For Completion by 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.

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: ____________________

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?

☐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)?

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☐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 deliver date:

3) Is the employee unable to perform any of his/her job functions due to the condition? ☐No ☐Yes
If so, identify the job functions the employee is unable to perform:

____

4) 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). Note to California Physicians: You may not disclose your patient's underlying diagnosis without their consent.:

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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 so, 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 so, 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:

____________Hour(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 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

Employee Name: ____ FMLA Claim #: ________________________________

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

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____ ________________________
Health Care Provider Signature Date

Please return to the employer's FMLA administrator at:

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