MetLife

Certification of health care provider for Employee's serious health condition Family and Medical Leave Act (FMLA)

Metropolitan Life Insurance Company

Things to know before you begin

- Please complete Section 1 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. Your response is required to obtain or retain the benefits FMLA of protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request.
- Remember to include your First name, Last name and Claim number in the spaces provided on all pages of this form.

Reminder: Forms marked as *lifetime*, *unknown*, *as needed*, *indeterminate* or the like, may be returned as incomplete.

SECTION 1: Employee information

First name	Middle initial	Last name	Claim number

Employer's name

SECTION 2: Instructions for the health care provider

Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency and length of a condition, treatments, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Limit your responses to the condition for which the employee is seeking leave. Be as specific as you can; terms such as *lifetime*, *unknown*, *as needed*, *or indeterminate* may not be sufficient to determine FMLA coverage. Without sufficient medical facts, this form may be returned as incomplete. Please be sure to sign the form on the last page.

Which of the following best describes your patient's medical condition? ☐ Pregnancy ☐ Injury ☐ Illness

If pregnancy, please provide date *(select one)*: ☐ Estimated delivery date

☐ Actual delivery date _____

What is the approximate date the condition commenced? _____

What is the estimated date the condition may conclude? _____

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

Was medication prescribed that may not be obtained over the counter? ☐ Yes ☐ No

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? If yes, please provide admission and discharge dates below. ☐ Yes ☐ No

Date admitted *(mm/dd/yyyy)*	Date discharged *(mm/dd/yyyy)*

First name	Middle initial	Last name	Claim number

Dates you treated the patient for this condition:

First visit *(mm/dd/yyyy)*	Last visit *(mm/dd/yyyy)*	Next visit *(mm/dd/yyyy)*

Are there any other treating physicians or consultants involved in your patient's care? ☐ Yes ☐ No

In the space provided below, please describe relevant medical facts, if any, related to the condition for which the employee seeks leave from work *(i.e., pregnancy complications, or any regimen of continuing treatment such as the use of specialized equipment).*

Note to California physicians: You may not disclose your patient's diagnosis without your patient's consent.

Job restriction details:

Were you provided with a job description for your patient, or did you discuss the essential functions of their job? ☐ Yes ☐ No

Is the employee unable to perform any of his/her job functions due to the condition? ☐ Yes ☐ No

If so, identify the job functions the employee is unable to perform:

SECTION 3: Amount of leave needed

Continuous absence details: Will your patient need to be absent from work for a single continuous period of time due to their own serious health condition? If so, please select the checkbox below and provide accurate or estimated dates for this period of absence.

☐ Single continuous absence period

Start date *(mm/dd/yyyy)*	End date *(mm/dd/yyyy)*

Intermittent absence details: Will your patient need an intermittent absence and/or reduced work schedule due to their own serious health condition? If so, please check the box below and provide approximately how long your patient will need the intermittent absence outlined below.

☐ Intermittent absence/Reduced work schedule

Start date *(mm/dd/yyyy)*	End date *(mm/dd/yyyy)*

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.

Example:

FREQUENCY of episode 02 times per: ☐ week, or ☒ month, or ☐ year

LENGTH of episode: ___ minute(s) 01 hour(s) ___ full day(s)

FREQUENCY of episode ___ **times per:** ☐ week, or ☐ month, or ☐ year

LENGTH of episode: ___ minute(s) ___ hour(s) ___ full day(s)

First name	Middle initial	Last name	Claim number

SECTION 4: Health care provider information

Physician - First name	Middle name	Last name

Physician area of specialty *(i.e., General Practitioner, Oncologist, Obstetrician)*

Office phone number	Office fax number

Office address	Suite

City	State	ZIP code

Please Read:

GINA Disclaimer: 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, 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.

Fraud Notice: Any person who knowingly and with intent to injure, defraud, or deceive any person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information is/may be guilty of a crime and may be prosecuted and punished. Penalties may include fines, civil damages and criminal penalties, including confinement in prison.

By signing below, I attest that I am the treating health care provider to the listed patient. The clinical information I am providing is in regards to the dates of absences listed above. I certify that my patient must be absent from work or have a modified work schedule due to this condition.

Sign Here	Signature of health care provider	Date *(mm/dd/yyyy)*

SECTION 5: How to submit this form

Mail:
MetLife Disability
P.O. Box 14590
Lexington, Kentucky 40512

Fax:
1-800-230-9531