

# Certification of Health Care Provider Family and Medical Leave Act

## Mayo Clinic Employee's Own Serious Health Condition

Form can be scanned into electronic medical record if requested by completing health care provider.

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 or the serious health condition of an eligible family member. Your response is required to obtain or retain the benefit of FMLA protections. Failure to provide a complete and sufficient medical certification within at least 15 days may result in a denial of your FMLA request.

**Employee Instructions:** Complete Section 1, save the form to your workstation (File + Save As), and send saved file as an email attachment to your health care provider (if Mayo Clinic provider, use Patient Online Services). **Request the provider return the form to you when complete.**

**Health Care Provider Instructions:** Complete Sections 2, 3, and 4. Print the form and sign in Section 4. **Return the signed form to the employee** for the employee to submit.

### Employee Submission Instructions:

Submit the form to Recovery and Claims Services (RCS) via the [Employee Incident Reporting and Medical Leave Requests](#) tile in the timekeeping system or at [ohs-prod-portalui.mayo.edu/RcsHome](https://ohs-prod-portalui.mayo.edu/RcsHome). Select the **Medical Certification Needed** line item for the leave case from the **My To Do List**, click **Upload Document** and locate saved document. Once the document is attached, click **Submit**. Microsoft Authenticator is required to access the submission site outside of the Mayo network.

### Section I. Employee/Patient Information – For completion by employee.

Employee Name (First Middle Last)		Birth Date (mm-dd-yyyy)
Employee ID	Job Title	Remote Worker <input type="checkbox"/> Yes <input type="checkbox"/> No

### Section II. Medical Facts – For completion by health care provider.

1. Is leave related to birth or placement of child, or pregnancy complications? <input type="checkbox"/> Yes <input type="checkbox"/> No Estimated delivery or placement date (mm-dd-yyyy):
2. State the employee's specific medical condition for which leave is required:
3. Has the employee been in hospice, hospitalized, or in a residential medical care facility for this medical condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, list all dates of admission and discharge related to this medical condition:
4. When did medical treatment for this condition begin? (mm-dd-yyyy)
5. List the last 4 dates you have treated the employee for this condition. (mm-dd-yyyy)
6. When is the employee's next appointment? (mm-dd-yyyy)
7. Was the employee referred to other health care providers for evaluation or treatment of this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, list specific referrals (provider/specialty/facility):
8. Was the employee prescribed any medications (not including over-the-counter items) related to this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, list prescribed medications:
9. What is the probable duration of this medical condition (be specific; terms such as "TBD," "indeterminate," or "unknown" are not sufficient to determine FMLA coverage):

### Section III. Amount of Leave Needed – For completion by health care provider.

10. Will the employee be incapacitated for a single, continuous period of time due to the medical condition, including any time for treatment and recovery? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, estimate the beginning and ending dates for the period of incapacity: (mm-dd-yyyy): through (mm-dd-yyyy):
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# Certification of Health Care Provider Family and Medical Leave Act (continued)

Employee Name (First Middle Last)	Birth Date (mm-dd-yyyy)
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## Section III. (continued)

11. Is the employee unable to perform any of their essential job duties due to this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, identify the essential job duties the employee is unable to perform:
12. Will the employee need follow-up treatment appointments? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, estimate <b>treatment</b> schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including recovery period:
13. Will the employee require a medically necessary reduced work schedule? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, estimate the <b>reduced work schedule</b> the employee needs, if any:      hours/day: days/week from (mm-dd-yyyy):      through (mm-dd-yyyy):
14. Due to the medical condition, is it <b>medically necessary for the employee</b> to be absent from work on an <b>intermittent basis</b> (periodically), including for any episodes of incapacity (ie, episodic flare-ups)? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, based on the employee's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the employee may have over the next 6 months: Frequency: _____ times per _____ week(s) _____ month(s) Duration: _____ hours or _____ day(s) per episode
15. Provide any additional medical facts to support the employee's request for leave covered under the Family and Medical Leave Act:

## Section IV. Health Care Provider Information

I certify the information is accurate and truthful to the best of my knowledge. I certify that I completed this form based on the medical information and facts derived from my treatment or care of the patient.

Provider Signature ▶		Date (mm-dd-yyyy)
Provider Printed Name (First Middle Last)	Title (MD, DO, etc)	Type of Practice
Address (Street, City, State, ZIP Code)		
Phone	Fax	Email

## Contact Information

Recovery and Claims Services  
Phone 507-422-0505

Mailing Address:  
Recovery and Claims Services  
Mayo Clinic  
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Rochester, MN 55905