Certification of Health Care Provider Family and Medical Leave Act

Mayo Clinic Employee's Family Member's Serious Health Condition

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

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. See Employee Submission Instructions at the end of this form to send completed document to Recovery and Claims Services. 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.

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.

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

Employee Name (First Middle Last)		Birth Date (mm-dd-yyyy)
Employee ID	Job Title	
Patient Name (First Middle Last)		Birth Date (mm-dd-yyyy)
Relationship to Employee	Other	

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

1. Is leave related to birth or placement of child, or pregnancy complications?
   ☐ Yes ☐ No Estimated delivery or placement date: (mm-dd-yyyy)
2. State the patient's specific medical condition for which leave is required:
3. Has the patient been in hospice, hospitalized, or in a residential medical care facility for this medical condition?
   ☐ Yes ☐ 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 patient for this condition: (mm-dd-yyyy)
6. When is the patient's next appointment? (mm-dd-yyyy)
7. Was the patient referred to other health care providers for evaluation or treatment of this condition?
   ☐ Yes ☐ No If Yes, list specific referrals (provider/specialty/facility):
8. Was the patient prescribed any medications (not including over-the-counter items) related to this condition?
   ☐ Yes ☐ 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):

Certification of Health Care Provider Family and Medical Leave Act (continued)

Employee Name (First Middle Last)	Birth Date (mm-dd-yyyy)

Section III. Amount of Care Needed: Family Member – For completion by health care provider.
When answering this section, 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.

10. Will the patient be incapacitated for a single, continuous period of time due to the medical condition, including any time for treatment and recovery? ☐ Yes ☐ No If Yes, estimate the beginning and ending dates for the period of incapacity:

    (mm-dd-yyyy) through (mm-dd-yyyy)

    During this time, will the employee need to provide care to the patient?"

    ☐ Yes ☐ No If Yes, explain the care needed and why such care is medically necessary:

11. Will the employee need to assist the patient with follow-up treatments/appointments, including any time for recovery?

    ☐ Yes ☐ No If Yes, estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including recovery period:

12. Will the employee need to assist the patient with ADLs such as transportation, emotional support, or care during episodic flares of this condition, and, if so, what is the expected frequency and duration of these absences?

    ☐ Yes ☐ No

    Frequency: ________ times per __________ week(s) _______ month(s)

    Duration: ________ hours or __________ day(s) per episode

13. 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	

Employee Submission Instructions:
Return the completed form to Recovery and Claims Services (RCS) via the Employee Incident Reporting and Medical Leave Requests tile in the timekeeping system, selecting **Leave Requests** on the **My Activities** tile, and using the "Send Message" button for the corresponding FMLA leave. Alternatively, the form can be faxed to RCS at 507-255-7198.

Contact Information

Mayo Clinic Recovery and Claims Services
Fax 507-255-7198
Phone 507-422-0505

Mailing Address:
Mayo Clinic, Recovery and Claims Services
200 First Street SW
Rochester, MN 55905