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

SECTION I --- EMPLOYER'S SECTION:

Employer name and contact: **Spartanburg County Human Resources**

Lisa Hart **(864) 596-3545 Fax (864)-596-3615**

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: **See job description attached**

Check if job description is attached: ✓

SECTION II --- EMPLOYEE's SECTION:

Please complete Section II 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 benefit of FMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. You have at least 15 calendar days to return this form to your employer.

Your name: _____

First **Middle** **Last**

Records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes are kept as confidential medical records in separate files/records from the usual personnel files. Only designated persons have access to medical information.

SECTION III --- HEALTH CARE PROVIDER's SECTION:

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.

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: _____

   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 medication, other than over-the-counter medication, prescribed? ___No ___Yes.

   Was the patient referred to 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: _____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions. 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):

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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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

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Signature of Health Care Provider **Date**