

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

SECTION I --- EMPLOYER'S SECTION:

Employer name and contact: Lisa Hart 864-596-3545 Fax: 864-596-3615

SECTION II --- EMPLOYEE'S SECTION:

Please complete Section II before giving this form to your family member or his/her 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 to care for a covered family member with a 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: _____

Name of family member for whom you will provide care: _____

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____

Describe the care you will provide to your family member and estimate leave needed to provide care:

Employee Signature

Date

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:

The employee listed above has requested leave under the FMLA to care for your patient. 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. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

PART B: AMOUNT OF CARE NEEDED: When answering these questions, 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:

4. Will the patient be incapacitated for a single continuous period of time condition, including treatment and recovery? ___No ___Yes

If so, estimate the beginning and ending dates for the period of incapacity: _____

During this time, will the patient need care? ___No ___Yes

Explain the care needed by the patient and why such care is medically necessary:

5. Will the employee need to attend follow-up treatment appointments, including any time for treatment and recovery? ___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:

Explain the care needed by the patient, and why such care is medically necessary:

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? ___No ___Yes___.

Estimate the hours the patient needs care on intermittent basis if any:

___ hour (s) per day; ___ days per week from ___ through ___

Explain the care needed by the patient, and why such care is medically necessary:

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ___No ___Yes___.

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

Does the patient need care during these flare-ups? ___No ___Yes___

Explain the care needed by the patient, and why such care is medically necessary:

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Signature of Health Care Provider

Date