ADMINISTRATIVE SERVICES HUMAN RESOURCES

FAMILY AND MEDICAL LEAVE ACT (FMLA) MEDICAL CERTIFICATION - FAMILY MEMBER

SECTION 1: To be completed by the EMPLOYEE:

Employee's Name: _____ Work Schedule (hours/days): _____

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

Relationship of family member to you: _____ If child, date of birth: _____

Describe care you will provide to your family member, and estimate the time off needed to provide care:

_____

_____

Date due in Human Resources: (refer to your FMLA Leave request form) _____

I authorize the health care provider to provide the information on this form for the purpose of determining if I qualify for an FMLA leave and for a Whatcom County Human Resources professional to contact the health care provider to authenticate and/or clarify information, if needed. I understand that if I do not provide a complete and sufficient medical certification, my FMLA leave request could be delayed or denied.

Employee's Signature: _____ Date: _____

An employee who fraudulently obtains FMLA leave will be subject to disciplinary action, up to and including termination.

SECTION 2: To be completed by the HEALTH CARE PROVIDER:

***Instructions**: A family member of your patient has requested leave under FMLA. Answer fully and completely ALL applicable parts. Give your **best estimate** based on your medical knowledge and experience. "Unknown" or "indeterminate" is not sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs care and do not provide any genetic information. Failure to provide sufficient information may cause the employee's FMLA request to be delayed or denied.*

Part A: Medical Facts

Approximate date the condition began: _____Probable duration: _____

Mark below as applicable:

1. Was the patient admitted for an overnight stay in the hospital, hospice, or residential medical care facility?
   ❑ Yes ❑ No If yes, date(s) of admission: _____
2. Date(s) you treated the patient for this condition: _____
3. Will the patient need to have treatment visits at least twice per year due to the condition? ❑ Yes ❑ No
4. Was medication, other than over-the-counter medication, prescribed? ❑ Yes ❑ No
5. Was the patient referred to other health care provider(s) for evaluation or treatment? ❑ Yes ❑ No
   If yes, state the nature of such treatments, expected duration of treatment, and the name of other medical provider(s): _____
   _____
6. Describe relevant facts, if any, such as symptoms, diagnosis, or any regimen of continuing treatment, related to the condition for which the patient needs care: _____
   _____

Part B: Amount of Leave Needed

1. Will the patient be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery?

   ❑ Yes ❑ No

   *(**"Incapacity"** is defined as the inability to work, attend school, or perform other regular daily activities due to a serious health condition, treatment therefore, or recovery therefrom)*

   If yes, estimate the continuous period of incapacity. From: _____(date) to _____(date)

   During this time, will the patient need care during the hours the employee works? ❑ Yes ❑ No

   If yes, explain the care needed by the patient and why such care is medically necessary:

   _____

2. Will the patient require follow-up treatments, including any time for recovery? ❑ Yes ❑ No

   If yes, estimate the treatment schedule, times needed for treatments, any scheduled appointments, and recovery periods, if necessary: _____

   _____

   During this time, will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? ❑ Yes ❑ No

   If yes, please estimate the hours the patient needs care on an intermittent basis, if any:

   _____ hour(s) per day; _____ day(s) per week From: _____(date) to: _____(date)

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

   _____

3. Will the condition cause episodic flare-ups which prevent the patient from participating in normal daily activities? ❑ Yes ❑ No

   If yes, is it **medically necessary** for the employee to be absent from work during the patient's flare-ups?

   ❑ Yes ❑ No If yes, please 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 incapacity that the patient may have:

   Frequency: _____ # times per ❑ week or ❑ month; **For:** _____ # hours or _____ # day(s) per episode

   From: _____ (date) to _____ (date)

   Does the patient need care during these flare-ups? ❑ Yes ❑ No

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

Name of Health Care Provider	**Signature of Health Care Provider**
Address	**Phone**
Type of Practice/Specialty	**Date**

FAX OR MAIL COMPLETED FORM TO:
Whatcom County Human Resources ● 311 Grand Avenue, Suite 107 ● Bellingham, WA 98225
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