MACALESTER

CERTIFICATION OF HEALTH CARE PROVIDER

INSTRUCTIONS: This form is to be completed by the patient's health care provider for the information necessary for a complete and sufficient medical certification. All of the information sought on this form relates only to the condition for which the employee is seeking to take FMLA and/or state law leave, if applicable. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

Mail or fax completed forms to: Macalester College, Employment Services, 1600 Grand Avenue, St. Paul, MN 55105; **Fax: 651-696-6612**.

SECTION I: (completed by EMPLOYER):

Employer Name:	Macalester College	**Contact:**	Jason Dempster or Randi Hartman
The Medical Certification must be returned by:			

SECTION II: (For Completion by the EMPLOYEE)

Please complete Section II before providing this form to your medical provider. The FMLA requires 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, 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. Furthermore, **you have 15 calendar days to return this completed form.**

Employee's Name: First Middle Last			
Employee's Job Title:		**Regular Work Schedule:**	
Employee's Essential Job Functions:			
☐ Check if job description is attached:			
Employee Signature:		**Date:** ____/____/_____ *(mm/dd/yyyy)*	

IF THE PATIENT IS *NOT* THE EMPLOYEE

Patient's Name: First Middle Last	
Patient's relationship to employee (e.g., husband, mother, child, etc.)**:**	
If child, what is the child's date of birth?	____/____/_____ *(mm/dd/yyyy)*
Describe the care you will provide to your family member	
Describe the estimated leave need to provide care	

SECTION III: For Completion by the HEALTH CARE PROVIDER

Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts.

HEALTHCARE PROVIDER INFORMATION

Printed name of Health Care Provider:	
Type of practice / Medical specialty:	
Address:	
Telephone number:	
Fax number:	
E-Mail:	

PART A: MEDICAL INFORMATION

Limit your response to the medical condition(s) for which the employee is seeking FMLA leave. Your answers should be your best estimate based upon your medical knowledge, experience, and examination of the patient. After completing Part A, complete Part B to provide information about the amount of leave needed. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

1) Approximate date the condition started or will start:	____/____/_____ *(mm/dd/yyyy)*
2) Best estimate of how long the condition lasted or will last:	

3) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

☐ **Inpatient Care**: The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s):_____

☐ **Incapacity plus Treatment**: *(e.g. outpatient surgery, strep throat)*
Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for more than three consecutive, full calendar days from ____/____/_____ *(mm/dd/yyyy)* to ____/____/_____ *(mm/dd/yyyy).*

The patient (☐ was / ☐ will be) seen on the following date(s): _____

The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider *(e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment)*

☐ **Pregnancy**: The condition is pregnancy. List the expected delivery date: ____/____/_____ *(mm/dd/yyyy)*

☐ **Chronic Conditions**: *(e.g. asthma, migraine headaches)* Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Permanent or Long Term Conditions**: *(e.g. Alzheimer's. terminal stages of cancer)* Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Conditions requiring Multiple Treatments**: *(e.g. chemotherapy treatments, restorative surgery)* Due to the condition, it is medically necessary for the patient to receive multiple treatments.

☐ **None of the above**: If none of the above condition(s) were checked (i.e. inpatient care, pregnancy) not additional information is needed. Go to page 4 to sign and date the form.

4) If needed, briefly describe other appropriate medical facts to the condition(s) for which the employee seeks FMLA leave. *(e.g. use of nebulizer, dialysis)* _____

_____

PART B: AMOUNT OF LEAVE NEEDED:

For the medical condition(s) checked in part A, complete all that apply. 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.

5) Due to the condition, the patient (☐ had / ☐ will have) **planned medical treatment(s)** (scheduled medical visits) *(e.g. psychotherapy, prenatal appointments)* on the following date(s): _____

_____

6) Due to the condition, the patient (☐ was / ☐ will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: (e.g. cardiologist, physical therapy) _____

Provide your best estimate of the beginning date ____/____/_____ *(mm/dd/yyyy)* and the end date ____/____/_____ *(mm/dd/yyyy)* for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s) including any period(s) of recovery *(e.g. 3 days/week)*_____

7) Due to the condition, it is medical necessary for the employee to work a **reduced schedule**.

Provide your **best estimate** of the reduced schedule the employee is able to work. From _____/_____/_____ *(mm/dd/yyyy)* to _____/_____/_____ *(mm/dd/yyyy)* the employee is able to work:
(e.g., 5 hours/day up to 25 hours a week)_____

_____

8) Due to the condition, the patient (☐ was / ☐ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your best estimate of the beginning date _____/_____/_____ *(mm/dd/yyyy)* and the end date _____/_____/_____ *(mm/dd/yyyy)* for the period of incapacity

9) Due to the condition, it (☐ was / ☐ is/ ☐ will be) medically necessary for the employee to be absent from work on an **intermitted basis** (periodically), including for any episodes i.e., flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur _____ times per (☐ day/☐ week / ☐ month) and are likely to last approximately _____ (☐ hours / ☐ days) per episode

PART C: ESSENTIAL JOB FUNCTIONS:

If provided, the information in Section II may be used to answer this question in combination with the job description if provided. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be *not able* to perform the essential job functions of the position during the during the absence for treatment(s).

10) Due to the condition, the employee (☐ was not able / ☐ is not able/ ☐ will not be able) to perform *one or more* of the essential job function(s). Identify at least one essential job function the employee is not able to perform:

_____

_____

Signature of Health Care Provider:	
Date of signature:	____/____/_____ *(mm/dd/yyyy)*

Definitions of a Serious Health Condition *(See 29 C.F.R. §§ 825.113-.115)*

Inpatient Care

- An overnight stay in a hospital, hospice, or residential medical care facility.
- Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.

Continuing Treatment by a Health Care Provider (any one or more of the following)

Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either:

- o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or,
- o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.

Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.

Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.

Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.

Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.