Pima County Family and Medical Leave (FMLA) Medical Certification from Health Care Provider for Family Member's Serious Health Condition

FORM
MC-02
09/2015

PIMA COUNTY

SECTION I: TO BE COMPLETED BY THE EMPLOYER

Employer Name: Pima County Contact: Human Resources - FMLA 520-724-8076 **Fax: 520-791-6514**

SECTION II: TO BE COMPLETED BY THE EMPLOYEE

Please complete this section before giving the form to your family member or his/her health care provider.

The Family and Medical Leave Act (FMLA) permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA due to your family member's serious health condition. **The completed form must be returned to HR-FMLA within 15 calendar days and may be faxed to HR-FMLA at 520-791-6514. Please do not send by email.** Incomplete forms delay processing and will be returned to you for completion. Failure to provide a complete and sufficient medical certification may result in denial of your FMLA request.

EMPLOYEE INFORMATION

Employee Name: _____ EIN: _____

Name of family member for whom you will provide care: (First Middle Last)

_____ Date of Birth: (mo/day/yr) _____

Family member's relationship to you: _____

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

_____ _____

Employee Signature Date

Pima County FMLA Medical Certification for Family Member's Serious Health Condition

SECTION III: TO BE COMPLETED BY THE HEALTH CARE PROVIDER

HEALTH CARE PROVIDER CONTACT INFORMATION:

Provider's Name: _____

Business Address: _____

_____

Type of practice / Medical specialty: _____

Phone: _____ Fax: _____

Email address: _____

INSTRUCTIONS TO THE HEALTH CARE PROVIDER: The employee listed on page 1 has requested leave under the FMLA to care for your patient, named below. Answer all applicable parts of pages 2 through 4 completely and legibly. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answers should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Limit your responses to the condition(s) for which the employee is seeking leave. Be as specific as you can. Terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Incomplete or unsigned forms will be returned to the health care provider for completion and/or correction. *If you have any questions regarding completion of this form, contact HR-FMLA at 520-724-8076. The completed form may be faxed to HR-FMLA at 520- 791-6514. Please do not send by email.*

Patient's Name: _____ Date of Birth: (mo/day/yr) _____

PART A: MEDICAL FACTS

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. 'Genetic Information' as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. **To comply with this law, we are asking that you do not provide any genetic information when responding to this request for medical information.**

1. Medical condition including diagnosis and/or symptoms:

   _____

   _____

2. Approximate date condition commenced: _____
3. Probable duration of condition: _____
4. Date(s) you treated the patient for this condition: _____
5. Was the patient (or will the patient be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ☐ No ☐ Yes If yes, date(s) of admission and facility name:

   _____
6. Will the patient need to have treatment visits at least twice per year due to the condition? ☐ No ☐ Yes
7. Was medication, other than over-the-counter medication, prescribed? ☐ No ☐ Yes
8. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g. physical therapist)? ☐ No ☐ Yes If yes, state the nature of evaluation or treatments and expected duration of treatment:

   _____
9. Is the medical condition pregnancy? ☐ No ☐ Yes If yes, expected delivery date: (mo/day/yr) _____

Pima County FMLA Medical Certification for Family Member's Serious Health Condition

PART B: AMOUNT OF LEAVE NEEDED
When answering these questions, keep in mind that your patient's need for care, to be provided by the employee, may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, and/or the provision of physical or psychological care. Base your answers on your knowledge of the medical condition and the patient's medical history.

10. Is there a single <u>continuous</u> period of time when the patient was (or will be) incapacitated due to the medical condition, including time for treatment and recovery? *(Incapacitated is defined as unable to work, attend school or perform other regular daily activities.)*

☐ No (Go to question 11.) ☐ Yes (Complete info below.)

Estimate the dates of this period of incapacity: *(Example: 6 weeks for surgery and recovery= from 1/1/2012 through 2/12/12)*

Patient will be incapacitated from (start) _____ through (end) _____
mo/day/yr mo/day/yr

During this time, will the patient need care (to be provided by the employee)? ☐ No ☐ Yes

Describe the care the patient will need (including level and amount) and why such care is medically necessary.
(Example: patient needs 24 hour care for wound care, cooking, bathing and transportation. Patient is unable to walk on own.)

_____

_____

11. Will the patient have follow-up treatments or appointments, including time for post-treatment recovery?

☐ No (Go to question 12.) ☐ Yes (Complete info below.)

Estimate treatment or appointment schedule, describe the care the employee will provide, and why such care is medically necessary. Include dates of scheduled appointments or frequency of appointments, time required for each appointment, recovery periods, and overall duration of treatment.

(Example: Chemo 1x /week, 3 hr treatment, and 1-2 day recovery, for 8 weeks. Employee to provide transportation to treatments and monitoring after treatments due to side effects.)

_____

_____

_____

_____

12. Will the patient require care or assistance on an intermittent basis, including time for recovery?

☐ No (Go to question 13.) ☐ Yes (Complete info below.)

Estimate how often the patient will need care on an intermittent basis:

_____ hour(s) per day; # _____ day(s) per week from (start) _____ through (end) _____
mo/day/yr mo/day/yr

Describe the care the employee will provide, including when care must be provided (e.g. morning, evening), and why such care is medically necessary. (*Example: patient needs assistance in morning with wound care, medication and hygiene.)*

_____

_____

_____

_____

Incomplete or unsigned forms will be returned to the health care provider for completion and/or correction.

13. Is the condition likely to cause episodic flare-ups which may prevent the patient from participating in normal daily activities? ☐ No ☐ Yes (Complete info below.)

Will the patient need care during these flare-ups? ☐ No ☐ Yes (Complete info below.)

Estimate the frequency of flare-ups and the duration of flare-ups that the patient may have over the next 6 months:
(Example: 1 episode every 3 months lasting 1-2 days)

Frequency: #_____ time(s) per #_____ week(s) OR #_____ month(s) (please circle weeks or months)

Duration: #_____ hour(s) or #_____ day(s) per episode (please circle hours or days)

Describe the care which the employee will provide, and why such care is medically necessary.
(*Example: patient must be monitored during flare-up including medication administration and hygiene.)*

ADDITIONAL INFORMATION: Describe any other relevant medical facts related to the condition(s) for which the patient is seeking leave or details for answers provided above (reference question numbers). Medical facts may include symptoms or any regimen of continuing treatment such as the use of specialized equipment. If needed, please attach additional sheets.

Incomplete or unsigned forms will be returned to the health care provider for completion and/or correction.

Signature of Health Care Provider Printed Name Date

The completed form may be faxed to HR-FMLA at 520-791-6514. Please do not send by email.