

Certification of Health Care Provider (Caretaker Leave)

SECTION I: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer name and contact: Marquette University, Human Resources
915 W. Wisconsin Ave., Room 185, Milwaukee, WI 53233
Phone: (414) 288-7305 | Fax: (414) 288-7425 | benefits@marquette.edu

SECTION II: For Completion by the EMPLOYEE: 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. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Employee's name: _____

Family member's name: _____

Relationship to employee: _____

SECTION III: For Completion by the HEALTH CARE PROVIDER: Your patient's family member 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 and duration:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

No Yes If yes, 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

2. Is the medical condition pregnancy? No Yes. If yes, expected delivery date: _____

3. 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):

PART B: AMOUNT OF LEAVE NEEDED

4. 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? No Yes If yes, dates of incapacity: _____

5. Will the employee’s family member need to attend follow-up treatment appointments? No Yes

6. Will the condition cause episodic flare-ups periodically? No Yes

Is it medically necessary for the employee to be absent from work during the flare-ups?

No Yes If yes, 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) _____ year _____ and duration _____ hours or _____ day(s) per episode

PART C: Signature

By signing the Certification of Health Provider, the provider and employee certify that all information is accurate to the best of their knowledge. Falsified information could result in a denied leave of absence request.

Ink Signature of Health Care Provider

Date

Ink Signature of Employee

Date