SALT LAKE COUNTY

Human Resources

Employee's Serious Health Condition

Certification of Health Care Provider
(Family and Medical Leave Act of 1993 as Amended)

SECTION I: To be completed by **Agency**

This form is confidential. Agency must maintain documents relating to medical certifications, recertifications or medical histories of employees created for FMLA as confidential medical records in a file separate from the personnel file.

Agency Contact Person and phone/email:

Employee's Job Title: Regular Work Schedule:

Essential Job Functions:

☐ Check if job description is attached

SECTION II: To be completed by **Employee**

You must submit this form to the Agency contact person listed above within 15 calendar days.

Your Name: Last Name First Name Middle Name/Initial Employee ID Number

SECTION III: To be completed by **Health Care Provider**

When completed, return form to the employee

Provider's name and business address:

Type of Practice/Medical Specialty: Phone No.

PART A: MEDICAL FACTS

1. Approximate date condition commenced:

Probably duration:

Date(s) you treated the patient for condition:

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ☐ Yes ☐ No

If yes, dates of admission:

Will the patient need to have treatment visits at least twice per year due to the condition? ☐ Yes ☐ No

Was medication, other than over-the-counter medication, prescribed? ☐ Yes ☐ No

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g. physical therapist)? ☐ Yes ☐ No

If yes, state the nature of such treatments and unexpected duration of treatment:

2. Is the medical condition pregnancy? ☐ Yes ☐ No

If yes, expected delivery date:

3. Use the information provided by the employer in Section I to answer this question. If the employer failed to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition: ☐ Yes ☐ No

If yes, identify the job functions the employee is unable to perform:

Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (e.g. symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including time for treatment and recovery? ☐ Yes ☐ No

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

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ☐ Yes ☐ No

If yes, are the treatments or the reduced number of hours of work medically necessary? ☐ Yes ☐ No

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each including recovery:

Estimate the part-time or reduced work schedule the employee needs, if any:

☐ hour(s) per day **OR**

☐ days per week from ☐ through ☐

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☐ Yes ☐ No

Is it medically necessary for the employee to be absent from work during the flare-ups? ☐ Yes ☐ No

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)

Duration: ☐ hours or ☐ day(s) per episode

ADDITIONAL INFORMATION

Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

Signature of Health Care Provider ☐ Date ☐