Date Issued: _____

CITY OF ST. LOUIS
CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS HEALTH CONDITION

SECTION I: For Completion by the Employer

INSTRUCTIONS to the Employer: 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 to Employee.**

Employer name and contact: _____

Employee's job title: _____ Regular work schedule: _____

Employee's essential job functions: _____
_____
_____

Check if job description is attached: _____

SECTION II: For completion by the Employee

INSTRUCTIONS to 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 due to your own serious health condition. **Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. This form must be returned with 15 calendar days.**

Your name: _____
First Middle Last

SECTION III: For completion by the HEALTH CARE PROVIDER

INSTRUCTION to the HEALTH CARE PROVIDER: Your patient 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.**

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. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "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 family member receiving assistive reproductive services.

PART A: MEDICAL FACTS

1. 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 physical therapy, chemotherapy, the use of specialized equipment, etc.) _____
   _____
   _____
   _____

2. Approximate date condition commenced: _____

   Probable duration of condition: _____

   Mark below as applicable:

   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical facility? No ____ Yes ____. If so, 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 ____.

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapy)? No _____ Yes ____. If so, state the nature of such treatments and expected duration of treatment: _____
_____

3. Is the medical condition pregnancy? No ____Yes ____. If so, expected delivery date: _____

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

   Is the employee unable to perform any of his/her job functions due to the condition? No ____ Yes____. If so, identify the job functions the employee is unable to perform: _____
   _____
   _____

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 any time for treatment and recovery?

   No ____ Yes ____. If so, estimate the beginning and ending dates for the 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?
   No ____ Yes ____. If so, are the treatments or the reduced number of hours of work medically necessary? No ____ Yes ____.

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

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

   Is it medically necessary for the employee to be absent from work during the flare-ups? No ____ Yes ____. If so, 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 _____ weeks(s) _____ month(s)
Duration: _____ hours or _____ days(s) per episode

Estimate the part-time or reduced work schedule the employee needs, if any:
_____ hour(s) per day;_____ days per week from _____ through _____

ADDITIONAL INFORMATION: INDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER: _____
_____
_____
_____
_____
_____

_____ _____
Signature of Health Care Provider Date

_____ _____
Signature of Employee Date

Printed Name of Health Care Provider: _____

Type of Practice: _____

Phone Number: _____ Fax Number: _____