



Human Resources – Disability Resources
516 High Street, Mail Stop 5221
Bellingham, WA 98225
(360) 650-3771 (Voice)
(360) 788-0071 (Confidential Fax)

**Medical Certification – Family Member
(Family Medical Leave Act)**

Please return this form within 15 calendar days.

Section I: For Completion by the EMPLOYEE

Please complete Section I before giving the form to a healthcare provider. The FMLA permits an employer to require that you submit timely and sufficient medical documentation in order to receive FMLA leave protections due to a serious health condition of a family member. You are responsible for ensuring Human Resources receives timely and sufficient documentation in order to obtain or retain FMLA leave protections.

Employee Name: _____

Name of family member for whom you will provide care: _____

Relationship: _____ If family member is your son or daughter, date of birth: _____

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

Employee Signature

Date

Section II: For Completion by the HEALTHCARE PROVIDER

The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. 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. Be as specific as you can; terms such as “lifetime,” “unknown,” or “indeterminate” may not be sufficient to determine FMLA coverage. Please limit your response to the condition for which the employee is seeking leave and be sure to sign the form on the last page. Please return the completed document via confidential **fax to 360.788.0071**.

Provider Name (please print): _____

Business Address: _____

Type of Practice/Specialty: _____

Telephone: _____

Fax: _____

Part A: MEDICAL FACTS to be completed by healthcare provider's office only

- 1) Approximate date condition commenced: _____
- 2) Date you first treated the patient for this condition: _____
- 3) Probable duration of condition: _____
- 4) The patient's illness, injury, impairment, or physical or mental condition: **(Mark all that apply)**
 - Is pregnancy and requires pre and/or post natal care (Due Date: _____)
 - Requires inpatient care (stay in a hospital, hospice, or residential medical care facility)
 - Involves a period of incapacity for a period of more than 3 consecutive, full calendar days where the patient is unable to work, attend school or perform other regular daily activities due to the condition or required medical treatment.
 - Incapacitation is following elective cosmetic surgery not related to an illness or injury.
 - Incapacitation is following restorative surgery due to an illness or injury.
 - Requires continuing treatment (in-person visits with healthcare provider) two or more times within approximately 30 days of the first day of incapacity and:
 - The first treatment occurred within seven days of the first day of incapacity, and
 - At least one in-person visit resulted in a regimen of continuing treatment under the supervision of a health care provider.
 - Is a chronic condition which:
 - Requires periodic medical visits (at least twice a year),
 - Continues over an extended period of time (including recurring episodes of a single underlying condition); and
 - May cause episodic rather than a continuing period of incapacity of more or less than 3 consecutive days (e.g., asthma, diabetes, epilepsy, etc.).
 - Is a permanent or long-term condition requiring a period of incapacity which medical treatment is not effective and the patient must be under the continuing supervision of a health care provider (i.e. Alzheimer's, a severe stroke, or the terminal stages of a disease).
- 5) Provide relevant medical facts related to the condition of the employee's family member (include symptoms, diagnosis and frequency of doctor visits): _____

Part B: CARE NEEDED to be completed by health care provider's office only

Care by the family member is medically necessary? No Yes

Full-time Care: The patient will be incapacitated for a single continuous period of time due to his/her medical condition.

Estimated dates of incapacity including recovery: Start: ___/___/___ End: ___/___/___
M D Y M D Y

Care assistance needed by the family member (mark all that apply) is:

- Basic medical
- Hygienic
- Nutritional
- Safety
- Transportation
- Provision of physical or psychological care
- Other: _____

Part-time or Intermittent Care: The patient will require medically necessary care by the family member on a part time or intermittent basis.

What is the reasonably expected frequency of care needed?

_____ times every _____ day(s); _____ week(s) _____ month(s)

Each frequency will require approximately following amount of care:

_____ hours; _____ day(s); _____ week(s).

Estimated dates care will be needed: Start: ___/___/___ End: ___/___/___
M D Y M D Y

If an end date is undetermined, how often is the patient evaluated? _____

Care needed by the family member (mark all that apply):

- Basic medical
- Hygienic
- Nutritional
- Safety
- Transportation needs
- Provision of physical or psychological care
- Other: _____

Signature of Healthcare Provider

Date

Please return completed document via our confidential fax at 360.788.0071.