



Human Resources – Disability/Medical Leave Services
516 High Street, MS: 5221
Bellingham, WA 98225-5996
Ph: 360.650.3771
Confidential Fax: 360.788.0071

**Family Medical Leave Act (FMLA)
Medical Certification – Employee’s condition**

Please return this form within 15 calendar days.

Section I: For Completion by the EMPLOYEE

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

Employee Name: _____ Job Title: _____

Authorization for Release of Medical Information

I hereby authorize my healthcare provider to disclose information so that comments contained in this Medical Certification may be clarified by my employer when necessary. I understand that I have the right to withdraw this authorization at any time and that such revocation must be in writing. Further, I understand that this authorization is optional and that I am responsible for ensuring complete and sufficient information to Human Resources for the purpose of FMLA protections.

By signing below, I am providing my authorization. Without prior revocation, authorization will expire one year from the date of signature.

Employee Signature: _____ Date: _____

Section II: For Completion by the HEALTHCARE 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 response to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page. Please return the completed document via confidential **fax to 360.788.0071**.

Provider Name: _____ Type of Practice/Specialty: _____

Business Address: _____

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 related requiring pre and 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 (include symptoms, diagnosis and frequency of doctor visits):

6) Based your patient's description of their job duties, is he/she prohibited from performing one or more of the duties due to this condition? No Yes

If yes, please list below the job duty(ies) the employee is unable to perform: (state "all" if applicable)
