Certification of Health Care Provider for Employee's Serious Health Condition
(Family Medical Leave Act)

Part A For Completion by the Employee: **Name:**	**Employee Number:**
Department:	**Title:**
Reports to:	**Status:** ◯ **Full-Time** ◯ **Part‐Time** ◯ **Temporary**
Today's Date:	**Hire Date:**
Employer's Address and Contact Information:	
Employee's Regular Work Schedule:	

Part B For Completion by the HEALTH CARE PROVIDER: Instructions: 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.

Provider's name and business address:	
Type of practice/Medical specialty:	
Telephone:	Fax:
MEDICAL FACTS	
1. Approximate date condition commenced:	Probable duration of condition:
Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility: Yes ◯ No ◯	If yes: Date(s) of admission: Date(s) you treated the patient for condition:
Will the patient need to have treatment visits at least twice a 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 expected duration of treatment:	
2. Is the medical condition pregnancy? Yes ◯ No ◯	If yes, expected delivery date:
3. Is the employee unable to perform any of his/her job functions due to the condition: Yes ◯ No ◯	
4. If yes, identify the job functions the employee is unable to perform:	

(continued on the next page)

5. Describe relevant medical facts related to the condition for which the employee seeks leave (such medical facts may include diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

PART C: AMOUNT OF LEAVE NEEDED	
6. 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? Yes ◯ No ◯	If yes, estimate the beginning and ending dates for the period of incapacity:
7. 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 appointment, including any recovery period:	
Estimate the part-time or reduced work schedule the employee needs, if any: _____ hour(s) per day; _____ days per week from _____ through _____	
8. 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, please 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: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER:	
Signature of Health Care Provider	**Date**

Return form to: Patient or BUREAU OF HUMAN RESOURCES, PMB 0141-2, 500 E CAPITOL AVE, PIERRE SD 57501 or FAX TO: 605-773-6947