



Office of Congressional Workplace Rights

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**Certification of Health Care Provider for Family Member's Serious Health Condition (Family and Medical Leave Act, as made applicable by the Congressional Accountability Act)**

INSTRUCTIONS to the EMPLOYING OFFICE: The Family and Medical Leave Act (FMLA), as made applicable by the Congressional Accountability Act (CAA), provides that an employing office 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 this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations issued by the Office of Congressional Workplace Rights (OCWR) Board of Directors at 825.306-825.308. Employing offices must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files, if the Americans with Disabilities Act and/or the Genetic Information Nondiscrimination Act apply, as made applicable by the CAA.

Employing office 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, as made applicable by the CAA, permits an employing office 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. If requested by your employing office, your response is required to obtain or retain the benefit of FMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your

FMLA request. OCWR regulations at 825.313. Your employing office must give you at least 15 calendar days to return this form. OCWR regulations at 825.305(b).

Your Name:

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First/ Middle/ Last

**SECTION III: For Completion by the HEALTH CARE PROVIDER**

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** Your patient has requested leave under the FMLA, as made applicable by the CAA. 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

**Form A**

**SECTION I: For Completion by the EMPLOYING OFFICE** responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests as defined in 29 C.F.R §1635.3(f), genetic services, as defined in 29 C.F.R. §1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. §1635.3(b). Please be sure to sign the form on the last page.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits us from requesting/ requiring genetic information of an individual or family member of the individual, except as specifically allowed by GINA. We ask that you not provide any genetic information when responding to this request for medical information. "Genetic information" includes an individual's family medical history, results of genetic tests, the fact that an individual or an individual/family member sought or received genetic services and genetic information of a fetus carried by an individual /family member/embryo lawfully held by an individual/family member receiving assistive reproductive services.

Provider's name and business address:

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Type of practice / Medical specialty:

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Telephone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

**PART A: MEDICAL FACTS**

1. 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 care facility?

No Yes If so, dates of admission:

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Date(s) you treated the patient for condition:

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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 therapist)? No Yes If so, state the nature of such treatments and expected duration of treatment:

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2. Is the medical condition pregnancy? No Yes If so, expected delivery date:

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3. Use the information provided by the employing office in Section I to answer this question. If the employing office 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:

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4. 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 the use of specialized equipment):

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#### 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:

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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 any recovery period:

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

\_\_\_\_\_ hour(s) per day; \_\_\_\_\_ days per week from \_\_\_\_\_ through \_\_\_\_\_

7. Will the condition cause episodic flare-ups 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:

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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. \_\_\_\_\_

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Signature of Health Care Provider \_\_\_\_\_

Date \_\_\_\_\_