Pima County Family and Medical Leave (FMLA) Medical Certification from Health Care Provider for Employee's Serious Health Condition

FORM
MC-01
09/2015

PIMA COUNTY

SECTION I: TO BE COMPLETED BY THE EMPLOYER

Employer Name: Pima County Contact: Human Resources - FMLA 520-724-8076 **Fax: 520-791-6514**

SECTION II: TO BE COMPLETED BY THE EMPLOYEE

Please complete this section before giving this form to your health care provider.

The Family and Medi cal Leave Act (FMLA) permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA due to your own serious health condition. **The completed form must be returned to HR-FMLA within 15 calendar days and may be faxed to HR-FMLA at 520-791-6514. Please do not send by email.** Incomplete forms delay processing and will be returned to you for completion. Failure to provide a complete and sufficient medical certification may result in denial of your FMLA request.

EMPLOYEE INFORMATION

Employee Name:_____ EIN:_____ Date of Birth:_____

Employee's Job Title:_____ Department:_____

Regular Work Schedule:_____

Physical Description Questionnaire: ☐ Not provided. ☐ See attached list. ☐ See attached Form PDQ.

Medical Condition(s) for which you are seeking leave: _____

_____

If this is related to a current Pima County ICA/Workers' Compensation claim, please check here. ☐

HEALTH CARE PROVIDER CONTACT INFORMATION:

Provider's Name:_____

Business Address:_____

_____

Type of practice / Medical specialty:_____

Phone:_____ Fax:_____

Email address: _____

Incomplete or unsigned forms will be returned to the health care provider for completion and/or correction.

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Patient/Employee Name: _____ Date of Birth: _____

SECTION III: TO BE COMPLETED BY THE HEALTH CARE PROVIDER

INSTRUCTIONS TO THE HEALTH CARE PROVIDER: Your patient, named above, has requested leave under the FMLA for the condition(s) listed on page 1. Answer all applicable parts of pages 2 and 3 completely and legibly. 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. Limit your responses to the condition(s) for which the employee is seeking leave. Be as specific as you can. Terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Incomplete or unsigned forms will be returned to the health care provider for completion and/or correction. *If you have any questions regarding completion of this form, contact HR-FMLA at 520-724-8076. The completed form may be faxed to HR-FMLA at 520- 791-6514. Please do not send by email.*

PART A: MEDICAL FACTS

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. '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 an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. **To comply with this law, we are asking that you do not provide any genetic information when responding to this request for medical information.**

1. Medical condition for which the patient is requesting leave, diagnosis, and/or symptoms:

   _____

2. Approximate date condition began: _____

3. Probable duration of condition: _____

4. Date(s) you treated the patient for this condition: _____

5. Was the patient (or will the patient be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility for this current condition? ☐ No ☐ Yes **If yes**, date(s) of admission and facility name:

   _____

6. Will the patient need to have treatment visits at least twice per year due to the condition? ☐ No ☐ Yes

7. Was medication, other than over-the-counter medication, prescribed? ☐ No ☐ Yes

8. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g. physical therapist)? ☐ No ☐ Yes **If yes**, state the nature of evaluation or treatments and expected duration of treatment:

   _____

9. Is the medical condition pregnancy? ☐ No ☐ Yes **If yes**, expected delivery date: mo/day/yr _____

10. Is the patient **unable** to perform any of the essential functions of the job due to the condition? ☐ No ☐ Yes

    (Example: unable to walk during flare-up, unable to lift more than 25 lbs during surgery recovery period.)

    _____

    _____

    _____

    _____

    _____

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PART B: AMOUNT OF LEAVE NEEDED

Please answer the following questions based on your knowledge of the medical condition and the employee's medical history.

11. Is there a single continuous period of time when the patient was (or will be) **unable to work** due to the medical condition, including time for treatment and recovery? ☐ No ☐ Yes
    (Example: 6 weeks for surgery and recovery, not working at all. Answer question 'Yes' from 1/1/2012 through 2/12/12)

    If yes, estimate the dates for this period: (start)_____ through (end)_____
    mo/day/yr mo/day/yr

12. Is it medically necessary for the patient to attend follow-up treatments or in-person appointments due to the medical condition? ☐ No ☐ Yes

    If yes, estimate treatment schedule, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period for treatment:
    (Example: Physical Therapy: 2 hours per session, 2x per week, from 2/15/12 - 3/31/12)

    _____

13. Is it medically necessary for the patient to work reduced hours because of the medical condition?
    ☐ No ☐ Yes

    If yes, estimate the reduced work schedule below. *(Example: 6 hours per day 4 days per week, from 2/13/12 to 3/31/12)*

    Patient is able to work #_____ hour(s) per day; #_____ day(s) per week from _____ through _____.
    mo/day/yr mo/day/yr

14. Is the condition likely to cause episodic flare-ups which may prevent the patient from performing his/her job functions? ☐ No ☐ Yes ***Use the essential job function information to answer this question***.

    Is it medically necessary for the patient to be absent from work during the flare-ups? ☐ No ☐ Yes
    If yes, explain:

    _____

    Estimate the frequency and duration of the flare-ups that the patient may have over the next 6 months:
    (Example: 1 episode every 3 months lasting 1-2 days)

    Frequency: #_____ time(s) per #_____ week(s) OR #_____ month(s) (please circle weeks or months)

    Duration: #_____ hour(s) or #_____ day(s) per episode (please circle hours or days)

ADDITIONAL INFORMATION: Describe any other relevant medical facts related to the condition(s) for which the patient is seeking leave or details for answers provided above (reference question numbers). Medical facts may include symptoms or any regimen of continuing treatment such as the use of specialized equipment. If needed, please attach additional sheets.

_____

_____

_____

_____

_____

Incomplete or unsigned forms will be returned to the health care provider for completion and/or correction.

_____

Signature of Health Care Provider Printed Name Date

Type of practice / Medical specialty:_____

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