Thurston County Family & Medical Leave Act
Health Care Provider Medical Certification

SECTION I: For Completion by the Employee

Complete this section before giving it to your licensed medical provider. You are required to submit a timely, complete, and sufficient medical certification to support a request for FMLA leave. Failure to do so may result in a delay or denial of your FMLA request (20 C.F.R. § 825.313).

1. Your Name: _____ Job Title: _____

   Office or Department: _____Your Supervisor: _____

   Regular Work Schedule and Hours: _____ Contact Phone #: _____

Reason for Family Medical Leave:

☐ **For my own serious health condition**
Instructions: Have your healthcare provider complete this medical certification, listing yourself as the patient.

☐ **To care for a family member during their serious health condition**
Instructions: Have your family member's healthcare provider complete this medical certification, listing your family member as the patient.
Relationship of family member to you (mother, father, spouse, child, etc.):_____

For childbirth, placement for adoption or foster care, and bonding, you do not need to complete this form. Please contact Human Resources to designate your leave as FMLA for childbirth, placement for adoption or foster care, and bonding.

Once your medical provider has filled out this form, please return to the Human Resources Department:

- In person at 3000 Pacific Ave SE, Suite 253, Olympia, WA 98501; or
- By mail at 3000 Pacific Ave SE, Olympia, WA 98501; or
- By fax at 360-357-2489.

SECTION II: For Completion by the Patient's Health Care Provider

Patient's Name: _____

Provider's Name: _____

Business Address: _____
Street City State Zip Code

Business Telephone: _____ Fax#: _____

PART A. Medical Facts

Our employee has requested FMLA. Please provide complete and full responses to all applicable questions to avoid returned forms. Please limit your responses to the condition for which the employee is seeking leave.

1. Date serious health condition commenced:_____

2. Probable duration of the condition: _____

3. Please **select (√)** which of the below categories of Serious Health Conditions applies and answer all applicable sub-questions:

_____ **I. Inpatient Care** for an overnight stay in a hospital, hospice, or residential medical care facility, including any period of *Incapacity*[1] or subsequent *Treatment*[2] in connection to inpatient care.

a. Dates of admission. Beginning Date: _____ End Date: _____

_____ **II. Incapacity and Treatment** for a period of *Incapacity*[1] of more than 3 consecutive, full calendar days (including any subsequent treatment or incapacity relating to the same condition).

a) Was the patient incapacitated for more than 3 consecutive, full calendar days? ☐ YES ☐ NO

b) Will Patient require treatment 2 or more times within 30 days of the first day of Incapacity? ☐ YES ☐ NO

c) Was the first (or only) treatment provided to the patient during an in-person visit with a health care provider within 7 days of the patient's first day of Incapacity? ☐ YES ☐ NO

d) Dates you treated the patient for the condition:_____

e) Was medication prescribed (not including over-the-counter medication)? ☐ YES ☐ NO

_____ **III. Chronic Condition Requiring Treatment** for periods of incapacity[1] (inability to work/perform regular daily activities):

a. Will the patient require at least two (2) *Treatment*[2] visits per year under the supervision of a health care provider? ☐ YES ☐ NO

b. Will the medical condition continue over an extended period of time (including recurring episodes of a single underlying condition)? ☐ YES ☐ NO

c. Will the medical condition cause episodic rather than a continuing period of incapacity (e.g. asthma, diabetes, epilepsy, etc.)? ☐ YES ☐ NO

_____ **IV. Permanent/Long-Term Conditions Requiring Supervision**

Any period of *Incapacity*[1] which is Permanent or Long-Term due to a condition for which treatment may not be effective (e.g. Alzheimer's, severe stroke, or terminal stages of disease).

_____ **V. Multiple Treatments (Non-Chronic Conditions)**

Absence(s) to receive multiple treatments for restorative surgery after an accident or injury/illness **OR** for a condition that could result in a period of incapacity of more than 3 consecutive, full calendar days if not treated (e.g. chemotherapy/radiation, physical therapy for severe arthritis, dialysis for kidney disease).

4. Describe other relevant medical facts related to the condition for which the employee seeks leave (e.g. symptoms, diagnosis, or any other regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

_____

_____

1. **Incapacity:** The inability to work, attend school, or perform other regular daily activities due to the serious health condition, treatment for, or recovery from.
2. **Treatment:** Examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.
3. **Regimen of Continuing Treatment:** A course of prescription medication or therapy requiring special equipment to resolve or alleviate the condition. It does not include the taking of over-the-counter medications (e.g. aspirin/antihistamines) and other similar activities that can be initiated without a visit to a health care provider.

5. Is the employee needed to provide care for a family member?

☐ YES ☐ NO ☐ N/A

If yes, please describe the care the employee will provide:

_____

_____

_____

_____

_____

PART B. Amount of Leave Needed

Please select (√) which of the below categories of leave is needed. Several questions seek a response to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based on your medical knowledge, experience, and examination of the patient.

6. **_____Leave for a Single Continuous Period of Time.** FMLA leave entitlement is limited to a total of 12 workweeks of leave during any 12-month period.

   Specify beginning and end dates: _____

7. **_____Intermittent Leave is needed in separate blocks of time for planned medical treatment and/or unforeseeable episodes of incapacity.**

   a. Will the employee need to attend follow-up treatment appointments? ☐YES ☐NO

Estimate the treatment schedule:

_____Times per ☐ Day or ☐ Week or ☐ Month for _____# of hours per appointment.

Recovery Period following each Treatment, if any: _____ # of hours.

b. Is it medically necessary for employee to be absent from work due to unforeseeable episodes of incapacity (e.g. flare ups)? ☐YES ☐NO

If Yes, please explain: _____

_____

Based on 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:

Frequency: _____ Times per _____ Day or ☐ Week(s) or ☐ Month(s)

Duration: _____ Hours or _____ Days per episode.

8. _____**Reduced Leave Schedule (part-time work)** reduces an employee's usual number of working hours per workweek, or hours per workday (i.e. a change in the employee's schedule for a period of time, normally from full-time to part-time) to recuperate from treatment or to recover from the serious health condition.

If so, provide the recommended reduced work schedule necessary and the duration:

Timeframe: Beginning Date: _____ to End Date: _____

Hour(s) per day: _____ | **Day(s)** per week: _____

9. Additional Information: _____

_____

_____

_____

_____

I certify that the information I have provided is true and correct to the best of my knowledge.

_____ _____

Signature of Health Care Provider **Date**

_____

Medical Practice or Specialty

Note to Health Care Provider:

Please do not provide any genetic information when responding to this request for medical information. Please note that information about the health condition of your patient may be provided as needed to complete the certification request.

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 employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "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.