**HEALTH CARE PROVIDER CERTIFICATION**

**FOR EMPLOYEE’S OWN CONDITION**

**Return to Sedgwick**

**Email: ChevronMail@sedgwick.com | Fax: 855-800-5116 | PO Box 14648, Lexington, KY 40512 | Phone: 1-888-825-5247**

**Employee Name: <Employee Name>**

**Claim Number: <File Number>**

**Instructions for the Employee:**   
Give this form to your health care provider. The Family and Medical Leave Act (FMLA) permits an employer 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. Your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b). Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.  
  
**Instructions for the Health care Provider:**

Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts, and sign the form. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of the employee. For FMLA purposes, a “serious health condition” means an illness, injury, impairment, or physical or mental condition that involves inpatient care or continuing treatment by a health care provider. Several questions seek a response as to the frequency or duration of the 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.

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. 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, information about the manifestation of a disease or disorder in an individual’s family members, the fact that an individual or an individual’s family member sought or received genetic services (including genetic testing, counseling, or education), or participated in clinical research which includes such 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.

National Provider Identifier (NPI):

Provider’s name:

Business address:

Type of practice / Medical specialty:

Telephone: ( ) Fax:( )

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**PART A: MEDICAL FACTS**

1. Approximate date condition commenced:

Provide your **best estimate** of how long the condition lasted or will last:

**Mark below as applicable:**

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

\_\_\_No \_\_\_Yes

If yes, dates of admission:

Date(s) you treated the patient for condition, including telemedicine visits conducted by video conference:

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 any other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

\_\_\_\_No \_\_\_\_Yes

If yes, state the nature of such treatments and expected duration of treatment:

1. Is the medical condition pregnancy? \_\_\_No \_\_\_Yes If so, expected delivery date:
2. For the following question, use the job information provided by the employer. If the employer 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 their job functions.

Is the employee unable to perform any of their job functions due to the condition: \_\_\_ No \_\_\_ Yes

If yes, identify the job functions the employee is unable to perform:

1. 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):

NOTE: In California and Connecticut, do not disclose the underlying diagnosis unless you have received consent from the patient.

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**PART B: AMOUNT OF LEAVE NEEDED**

1. Will the employee be incapacitated for a single continuous period of time due to their medical condition, including any time for treatment and recovery? \_\_\_No \_\_\_Yes

If yes, estimate the beginning and ending dates for the period of incapacity: \_\_\_\_\_\_\_\_\_\_ through \_\_\_\_\_\_\_\_\_\_\_

1. Will the employee need to work part-time or on a reduced schedule because of the employee’s medical condition? \_\_\_No \_\_\_Yes

If yes, are a reduced number of hours of work medically necessary? \_\_\_No \_\_\_Yes

Estimate the part-time or reduced work schedule the employee needs, if any:\_\_\_ hour(s) per day; \_\_\_ days per week

Estimate the beginning and end date of the part-time or reduced work schedule: through

1. Will the employee need to attend follow-up treatment appointments because of the employee’s medical condition?

\_\_\_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 (e.g., 1 appointment every 3 months, and requires 1 day of recovery per appointment):

Frequency: \_\_\_\_\_ appointment(s) every \_\_\_\_\_ week(s) ***or*** \_\_\_\_\_ month(s)

Duration: \_\_\_\_\_ hours ***or*** \_\_\_ day(s) per appointment

Estimate the beginning and end date of the follow-up treatment appointments: through

1. Will the condition cause episodic flare-ups periodically that prevent the employee from performing their job functions? \_\_\_\_No \_\_\_\_Yes

Is it medically necessary for the employee to be absent from work during episodic flare-ups? \_\_\_\_No \_\_\_\_ Yes

If yes, 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) ***or*** \_\_\_\_\_ month(s)

Duration: \_\_\_\_\_ hours ***or*** \_\_\_ day(s) per episode

Estimate the beginning and end date of the episodic flare-ups: through

**ADDITIONAL INFORMATION:**

***If applicable, identify corresponding question number with your additional or continued answer.***

Signature of Health care Provider Date