Certification of Healthcare Provider for Family Member's Serious Health Condition (Family and Medical Leave Act)

INSTRUCTIONS to the EMPLOYEE:

YOU MUST RETURN THE COMPLETED FORM WITHIN 15 DAYS. FAILURE TO PROVIDE A COMPLETE AND SUFFICENT CERTIFICATION IN A TIMELY MANNER MAY RESULT IN THE DENIAL OF YOUR FMLA REQUEST.

Employee: ____ Employee ID: ______________
First Middle Last If available

My Mailing Address: ____ Phone: ______________

I am caring for: ____ Relation: ______________
First Middle Last
Family member date of birth: ____/____/____

Describe the care you will provide to your family member and estimate leave needed to provide care:

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Employee's Signature: ______________________________________ Date: ______________

INSTRUCTIONS to the FAMILY MEMBER (PATIENT):

By my signature below, I demonstrate my informed consent and authorization to allow my healthcare provider to release, disclose and communicate to my family member's employer or employer representative such healthcare records and information concerning my current medical condition(s) as is necessary to support my family member's request for a leave of absence and/or any additional benefits his/her employer may provide. I further authorize my family member's employer or employer representative to contact my healthcare provider directly for the purposes of clarification and verification of the authenticity of this certification. This authorization shall be valid for one (1) year from the date shown below, unless revoked by me in writing at an earlier date. Although I understand that I may revoke this authorization in writing at any time, I also understand that any such revocation will not apply to any information that has already been released in reliance on this authorization, and that any revocation may have an adverse effect on the receipt of my family member's Employer-provided benefits. I understand that information disclosed by my healthcare provider to my family member's employer or employer representative may be subject to redisclosure and not protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The information shall not be released to my family member's immediate supervisor.

I authorize my healthcare provider to provide this certification form directly to my family member's employer via fax or mail.

Family Member's Signature: ______________________________ **Date:** ______________
(Patient)

If the family member (Patient) does not sign this authorization and upon request, the employee fails to obtain clarification of incomplete or inconsistent responses, the employee's leave of absence may be denied under FMLA. 29 C.F.R. §825.307(a). You have a right to obtain a copy of this authorization after you sign it.

The 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 the serious health condition of a family member. If requested by your employer, 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.