Certification of Healthcare Provider for
Employee'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: _____

Telephone: (____) _____

By my signature below, I demonstrate my informed consent and authorization to allow my healthcare provider to release, disclose and communicate to my employer or employer representative such healthcare records and information concerning my current medical condition(s) as is necessary to support my request for a leave of absence and/or any additional benefits my employer may provide. I further authorize my 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 Employer-provided benefits. I understand that information disclosed by my healthcare provider to my 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 immediate supervisor

I authorize my healthcare provider to complete and provide this certification form directly to my employer via fax or mail.

Employee's Signature: _____ Date: _____

If the employee does not sign this authorization and employee fails to obtain clarification of incomplete or inconsistent responses upon request, the employee's leave may be denied, 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 your own serious health condition. 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.