CITY OF OMAHA

CERTIFICATION OF HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS HEALTH CONDITION– FAMILY AND MEDICAL LEAVE ACT (FMLA)

Return to
City of Omaha
Human Resources Department, Benefits Division
ATTN: Amanda Stoffel
1819 Farnam Street, Suite 506
Omaha, NE 68183
(402) 444-6907
FAX (402) 444-5314

SECTION I: FOR COMPLETION BY THE EMPLOYEE

INSTRUCTIONS TO THE EMPLOYEE: Please complete Section I before giving this form to your medical provider. 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. 29 C.F.R. § 825.313. Your employer must give you at least fifteen (15) calendar days to return this form. 29 C.F.R. § 825.305(b).

Employee's Name: ______________________________

Employee's Job Title: ______________________________

Regular Work Hours: ______________________________

Employee's
Essential Job Functions: ______________________________

____

Job Description Attached? ☐ YES ☐ NO

SECTION II: FOR COMPLETION BY THE HEALTH CARE PROVIDER

INSTRUCTIONS TO THE HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a 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. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3€ Please be sure to sign the form on the last page.

Provider's
Name: ______________________________

Business
Address: ______________________________

Type of Practice/
Medical Specialty: ______________________________

Telephone: ______________________________

FAX: ______________________________

PART A: MEDICAL FACTS

1. Approximate date condition commenced: ______________________________

   Probable duration of condition: ______________________________

   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:

   ____

   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 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:

   ____

2. Is the medical condition pregnancy? ☐ NO ☐ YES If YES, expected delivery date:

   ____

3. Use the information provided in SECTION I to answer this question. If there is no listing of the employee's essential job functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   Is the employee unable to perform any of his/her job functions due to the condition? ☐ NO ☐ YES

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

   ____

4. 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):

   ____

   ____

   ____

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ☐ NO ☐ YES

   If YES, estimate the beginning and ending dates for the period of incapacity:

   ____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ☐ NO ☐ YES

   If YES, are the treatments or the reduced number of hours of work medically necessary? ☐ NO ☐ YES

   Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recover period:

   ____

   Estimate the part-time or reduced work schedule the employee needs, if any:

   ________ Hours per day; _________ Days per week from ______________ through ______________

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☐ NO ☐ YES

   Is it medically necessary for the employee to be absent from work during the 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 six (6) months (e.g. one (1) episode every three (3) months lasting from one (1) to two (2) days):

   Frequency: _____________ Times per _____________ Week(s) _____________ Month(s)

   Duration: _____________ Hours or _____________ Days(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER

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Signature of Health Care Provider **Date**