# CITY OF OMAHA

## CERTIFICATION OF HEALTH CARE PROVIDER FOR FAMILY MEMBER'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) 444-5300*
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 family member or his/her 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 to care for a covered family member with a 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).

Your Name:
(First, Middle, Last) ______________________________

Name of Family Member
(First, Middle, Last) ______________________________

Relationship of Family Member
to You: ______________________________

If Family Member is your Son or
daughter, their Date of Birth: ______________________________

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

______________________________

______________________________

______________________________

______________________________ ______________________________
**Employee Signature** **Date**

## SECTION II: FOR COMPLETION BY THE HEALTH CARE PROVIDER

**INSTRUCTIONS TO THE HEALTH CARE PROVIDER:** The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. 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 patient needs 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€ Page 4 provides space for additional information, should you need it. 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. 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: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ☐ NO ☐ YES

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

______________________________________________

During this time, will the patient need care? ☐ NO ☐ YES

Explain the care needed by the patient and why such care is medically necessary:

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

5. Will the patient require follow-up treatments, including any time for recovery? ☐ 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:

______________________________________________

Explain the care needed by the patient, and why such care is medically necessary:

______________________________________________

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? ☐ NO ☐ YES

Estimate the hours the patient needs care on an intermittent basis, if any:

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

Explain the care needed by the patient and why such care is medically necessary:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ☐ NO ☐ YES

   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

   Does the patient need care during these flare-ups? ☐ NO ☐ YES

   Explain the care needed by the patient and why such care is medically necessary:

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______________________________________________________________________________

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______________________________________________________________________________

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

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____________________________________________ ______________________________

**Signature of Health Care Provider** **Date**