CERTIFICATION OF HEALTH CARE PROVIDER FOR MEDICAL LEAVE
Family and Medical Leave Act of 1993 ("FMLA")

Employee's Statement: To be completed by EMPLOYEE

The FMLA requires that you submit a timely, complete, and sufficient medical certification to support a request for FMLA due to your or your covered family member's serious health condition.
Failure to submit a timely, complete, and sufficient medical certification may result in a delay or denial of your leave request.

Employee Name: «EmployeeFullName» EmployerName: «EmployerName»

Employee ID No. (NOT SSN) _____ Employee's work location: _____ Date of Birth: ___ / ___ /___

Employee's current work schedule:

Day:	M	T	W	Th	F	Sa	Su
Hours							

Total average hours worked per week: _____ If irregular schedule, please describe: _____

Please specify the period of time during which you are requiring any sort of leave: From: ___ / ___ /___ through ___ / ___ /___
Will you require intermittent leave? ☐ Yes ☐ No | Anticipated Return to Work Date: ___ / ___ /___

Part A - Reason for Leave (choose one from numbers 1-4):
1. ☐ Your own health condition preventing you from performing the essential functions of your job and/or daily living
2. ☐ Your Own Pregnancy:
   a. Estimated date of delivery: ___ / ___ /___ Actual delivery date ___ / ___ /___
3. ☐ Bonding with a new child in your home:
   a. Natural Child Date of Birth ___ / ___ /___
   b. Adopted Child Date of Birth ___ / ___ /___ Date of Adoption ___ / ___ /___
   c. Foster Child Date of Birth ___ / ___ /___ Date of Placement ___ / ___ /___
   If requesting a leave for bonding, the Health Care Provider Statement is NOT required. Return the signed form to Reed Group along with proof of birth, adoption or foster placement.
4. ☐ To care for family member with a serious health condition:

Family Member Name_____ | Relationship: ☐ Child ☐ Parent ☐ Spouse ☐ Other

   a. If Other, please describe relationship (additional family members and/or domestic partner may not be covered by FMLA but may qualify under state laws and/or Company Policy) _____
   b. If caring for a child, give Date of Birth : ___ / ___ /___
   c. What care will you be providing the family member: _____

Part B - Employee Acknowledgement: By placing my signature below I acknowledge and certify that:
- All information contained herein is true and correct.
- I have not made and will not make alterations to the Health Care Provider's Statement.
- I understand that it is my responsibility to return this completed Statement with the Health Care Provider's Statement ("Certification") and any clarifying, missing, or incomplete information later requested to Reed Group, within the specified timelines.
- I understand failure to provide a timely, complete, and sufficient Certification may result in a denial of my FMLA request.

IMPORTANT NOTICE: 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 employees or their family members. In order to comply with this law, **we are asking that you not provide any Genetic Information** when responding to this request for medical information, unless, with respect to leave to care for a family member with a serious health condition, failure to provide the information will result in an incomplete or insufficient certification. **"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, the fact that an individual or an individual's family member sought or received genetic 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.

Employee's Signature**:** _____ Date: _____

Health Care Provider Statement: To be Completed by Health Care Provider

Employee Name: «EmployeeFullName» EmployerName: «EmployerName»

Patient Name (if different from Employee): _____

IMPORTANT NOTICE TO PROVIDER: This employee has requested leave either for his/her own serious health condition or to care for a family member with a serious health condition. **A COMPLETED FORM is necessary to determine whether the employee's requested time off is available and protected by the FMLA and/or applicable state laws.**

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Part A – Medical Facts:

1. The patient's condition meets the following factors(s) (necessary to determine whether the condition meets the definition of a "Serious Health Condition" as defined in the FMLA). Complete all that apply:

a. ☐ Inpatient Care in hospital, hospice or residential medical care facility:
Date of Admission ____ / ____ /___ Date of Discharge: ____ / ____ /____

b. ☐ Pregnancy:
i. Are there complications? ☐ Yes ☐ No
ii. If yes, describe the complications. (Do not answer without patient consent in CA, ME (or RI):_____
_____
iii. Scheduled for approximately _____ Prenatal Visits
iv. Estimated Date of Delivery ____ / ____ /___
v. Actual Delivery Date ____ / ____ /___

c. ☐ Incapacity Plus Treatment:
The patient's period of incapacity has or will exceed three (3) days AND the patient will require two (2) or more office visits within thirty (30) days of the first day of incapacity;
OR
One (1) office visit resulting in a regimen of continuing treatment (e.g., continuing treatment under the supervision of a physician, nurse, or physician's assistant or by health care provider's referral to a provider of health care services, such as a physical therapist).

d. ☐ Chronic Condition: requires at least 2 visits per year for treatment by a health care provider, continues over an extended period of time and may cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.)

e. ☐ Permanent Long Term Condition: may not require treatment, but requires the supervision of a health care provider (such as Alzheimer's Disease, terminal illness, severe stroke).

f. ☐ Conditions Requiring Multiple Treatments: period of absence to receive multiple treatments and to recover from treatments either for: a condition that would likely result in a period of incapacity for more than 3 days in the absence of medical intervention or treatment (such as chemotherapy for cancer, dialysis for kidney disease, or physical therapy for severe arthritis); **OR** restorative surgery after an accident or injury.

g. ☐ None of the above.

2. If the employee is requesting leave for his/her own health condition, is he/she unable to perform any of his/her essential job duties due to this condition? ☐ Yes ☐ No

a. If yes, identify the essential job duties the employee is unable to perform: _____

3. Provide the medical facts that support the identification of this condition as a "Serious Health Condition" for which the patient needs FMLA leave from work (may include diagnosis, symptoms, treatment or supervision, surgery, hospitalization, etc.) and the treatment or symptoms of this condition that prevent the employee from performing his/her essential job duties.
(Do not provide medical facts without patient consent in CA, ME or RI. Do not provide diagnosis without patient consent in CA, CT, ME, or RI.):

_____

_____

_____

Optional: Please list the ICD-9 code(s) **(Do not complete without patient consent in CA, CT, ME, or RI)**: _____

4. If the employee is requesting leave to care for a family member, what care does the patient need from the employee?

_____

5. a. What is the approximate date the condition commenced? _____

b. When was the first time you treated the patient for this condition? _____

c. When was the most recent date you treated the patient for this condition? _____

d. When is the patient's next scheduled appointment? _____

e. What is the probable duration of this condition (Please provide your best estimate; "unknown" or "indeterminate" may not be sufficient to determine FMLA coverage)? _____

Part B – Treatment Needed and Schedule:

a. The employee will need leave for Scheduled Treatments/appointments (physical therapy, chemo, etc.): Treatments to begin ____ / ____ /____ through ____ / ____ /____.

b. Treatments will be ___ time(s) per _____ (7, 30, 365) days (e.g., 2 times every 30 days). Each treatment will last approximately _____ hours.

c. Is medication prescribed for this condition (other than over-the-counter medication)? ☐ Yes ☐ No

d. Was the patient referred to other health care provider(s) for evaluation or treatment? ☐ Yes ☐ No

e. Name and contact information of the health care provider to whom patient was referred: _____
_____

f. Specialty of health care provider to whom patient was referred **(Do not provide specialty without patient consent in CA, CT, ME, or RI)**:_____

Part C – Amount of Leave Needed (more than one leave type may be selected):

Fill in the corresponding column(s) indicating the type of leave(s) your patient's serious health condition requires. Enter the START and END dates of the appropriate type(s) of FMLA leave in the table below.

For the frequency or duration of the patient's condition or treatment, please provide your best estimate based upon your medical knowledge, experience and examination of the patient. **Terms such as "unknown" or "indeterminate" may not be sufficient to determine FMLA coverage.**

I. **CONTINUOUS/REGULAR LEAVE** If the employee requires leave for a single continuous period of time, please complete this section.	II. **INTERMITTENT LEAVE** If it is medically necessary for the employee to take leave in intermittent periods of time please complete this section.	III **REDUCED-SCHEDULE LEAVE** If it is medically necessary for the employee to reduce the number of hours of the employee's daily or weekly work schedule, please complete this section.
Start date of leave: ____ / ____ /____ End date of leave: ____ / ____ /____	First date of leave: ____ / ____ /____ Anticipated end date of leave: ____ / ____ /____	Start date of reduced leave: ___ / __ /___ Date employee may return to full duty: ____/____/____
	1. In your opinion, how often is the employee likely to need leave for this condition? Number of times absent: ____ times every _____ days (use 7, 30, 365) (e.g., 2 times every 30 days) **2. In your opinion, how long will each period of absence last?** Each episode of incapacity will last approximately ____ hours **OR** _____days (e.g., 3 hours or 2 days)	Please provide the schedule the employee is able to work: ___ days per week ___ hours per day and/or week

Part D – Health Care Provider Signature:
I certify the above information is accurate and truthful to the best of my knowledge. I certify that I completed this form based on the medical information and facts derived from my treatment or care of the patient.

Signature: _____ Date Form Completed and Signed: _____

Print Name: _____ Title (MD, DO, etc.): _____ Type of Practice: _____

Address: _____

Phone Number: _____ Fax Number: _____

(Form Revised 2/16/2012)