**HEALTH CARE PROVIDER CERTIFICATION**

**FOR FAMILY MEMBER’S CONDITION**

**Return to Sedgwick**

**Email: ChevronMail@sedgwick.com | Fax: 855-800-5116 | PO Box 14648, Lexington, KY 40512 | Phone: 1-888-825-5247**

**Employee Name: <Employee Name>**

**Claim Number: <File Number>**

**Instructions to the Employee:**Complete this section before giving this form to your family member or their health care provider. The Family and Medical Leave Act (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. 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 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.  
  
Name of family member for whom you will provide care:

First Middle Last

Relationship of family member to you:

Spouse⁪ Father Mother Child Domestic Partner

Other:

If family member is your father, mother, or child, provide date of birth:

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

Employee Signature Date

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**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 care. The last page provides space for additional information, should you need it. Please be sure to sign the form on the last page.

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 an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. ‘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, information about the manifestation of a disease or disorder in an individual’s family members, the fact that an individual or an individual’s family member sought or received genetic services (including genetic testing, counseling, or education), or participated in clinical research which includes such 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.

Notwithstanding the foregoing, family medical history may be provided when FMLA caregiver leave is requested to care for a family member, as long as the family medical history is limited to information needed to substantiate the serious health condition of the family member to be cared for.

National Provider Identifier (NPI):

Provider’s name:

Business address:

Type of practice / Medical specialty:

Telephone: ( ) Fax:( )

**PART A: MEDICAL FACTS**

1. Approximate date condition commenced:

Provide your **best estimate** of how long the condition lasted or will last:

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, including telemedicine visits conducted by video conference:

Will the patient need to have treatment visits at least twice per year due to the condition? \_\_\_No \_\_\_ Yes

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Was medication, other than over-the-counter medication, prescribed? \_\_\_No \_\_\_Yes

Was the patient referred to any 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:

1. Is the medical condition pregnancy? \_\_\_No \_\_\_Yes If so, expected delivery date:
2. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

NOTE: In California and Connecticut, do not disclose the underlying diagnosis unless you have received consent from the patient.

**PART B: AMOUNT OF CARE 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:

1. 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:

1. 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 recovery period:

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

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Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period (e.g., 1 appointment every 3 months, and requires 1 day of recovery per appointment):

Frequency: \_\_\_\_\_ appointment(s) every \_\_\_\_\_ week(s) ***or*** \_\_\_\_\_ month(s)

Duration: \_\_\_\_\_ hours ***or*** \_\_\_ day(s) per appointment

Estimate the beginning and end date of the follow-up treatment appointments: \_\_\_\_\_\_\_\_\_\_\_ through \_\_\_\_\_\_\_\_\_\_\_

1. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?

\_\_\_ No \_\_ Yes

Estimate the beginning and end date of the part-time or reduced work schedule: through

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

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period (e.g., 1 appointment every 3 months, and requires 1 day of recovery per appointment):

Frequency: \_\_\_\_\_ appointment(s) every \_\_\_\_\_ week(s) ***or*** \_\_\_\_\_ month(s)

Duration: \_\_\_\_\_ hours ***or*** \_\_\_ day(s) per appointment

1. Will the condition cause episodic flare-ups periodically that prevent 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 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: \_\_\_\_\_ times per \_\_\_\_\_ week(s) ***or*** \_\_\_\_\_ month(s)

Duration: \_\_\_\_\_ hours ***or*** \_\_\_ day(s) per episode

Estimate the beginning and end date of the episodic flare-ups: through

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:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **If the leave being requested is to care for a child age 18 or older**, does your patient need assistance in performing three or more activities of daily living (ADLs) or instrumental activities of daily living (IADLs)?

\_\_\_\_ No  \_\_\_\_ Yes

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**ADDITIONAL INFORMATION:**

***If applicable, identify corresponding question number with your additional or continued answer.***

Signature of Health care Provider Date