Reset Form

Certification of Health Care Provider for
Employee's Serious Health Condition

STATE OF MAINE
All Executive Branch Employees

SECTION I – FOR COMPLETION BY HUMAN RESOURCES REPRESENTATIVE

Employee Name	Employee ID (*e.g.* TAMS ID)	Department
HR Representative Name	**HR Representative Phone**	**HR Representative Fax**

HR Representative Email

Date Certification Provided to Employee	Certification Due Date

The employee's job description ☐ is / ☐ is not attached. If the job description is not attached, please list the employee's job functions:

SECTION II – FOR COMPLETION BY THE EMPLOYEE

The State of Maine's Family and Medical Leave Policy ("FMLA Policy") requires that an employee seeking Family Medical Leave (FML) because of a need for leave due to a serious health condition submit a medical certification issued by the employee's healthcare provider.

Please complete Section II before giving this form to your medical provider. The FMLA Policy requires that you submit a timely, complete, and sufficient medical certification to support a request for FML due to your own serious health condition. Your response is required to obtain or retain the benefit of FMLA Policy protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FML request. **You have 15 calendar days to return this form.** Please contact your HR Representative with any questions.

Regular Work Schedule (Select One)

☐ I am scheduled to work 40-hours per week, Monday to Friday.

Daily Start Time: _____ Daily End Time: _____

☐ I am not scheduled to work 40-hours per week, Monday to Friday. My regular work schedule is:

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Start Time							
End Time							

SECTION III – FOR COMPLETION BY THE HEALTHCARE PROVIDER

INSTRUCTIONS to the HEALTHCARE PROVIDER: Your patient has requested leave under the State of Maine's FMLA Policy. Please 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 FML coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, genetic services, or the manifestation of disease or disorder in the employee's family members. 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, 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.

PART A: PROVIDER INFORMATION

Provider's Name	Type of Medical Practice / Medical Specialty

Business Address

Phone	Fax

PART B: MEDICAL FACTS

Patient Name	Date(s) you treated the patient for condition:

Approximate Date Condition Commenced	Probable Duration of the Condition

Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part C.

☐ **Inpatient Care**. The patient has or is expected to be admitted for an overnight stay in a hospital, hospice, or residential medical facility.

Dates of Admission: _____

☐ **Pregnancy.** The condition is pregnancy.

Expected Delivery Date: _____

(CONTINUED ON NEXT PAGE)

PART B: MEDICAL FACTS (CONTINUED)

☐ **Incapacity and Treatment**. Due to the condition, the patient has been or is expected to be incapacitated for more than three consecutive full calendar days on the following dates: _____.

This condition ☐ did / ☐ did not result in a course of prescription medication (non-over the counter) or therapy requiring special equipment.

☐ **Chronic Conditions**. (*e.g.* asthma, migraine headaches) Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Permanent or Long Term Conditions**: (*e.g.* Alzheimer's, terminal stages of cancer) Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Conditions requiring Multiple Treatments:** (*e.g.* chemotherapy treatments, restorative surgery) Due to the condition, it is medically necessary for the patient to receive multiple treatments.

PART C: AMOUNT OF LEAVE NEEDED

Check all that Apply:

☐ **Continuous Leave.** Due to the condition, the employee was or will be incapacitated for a continuous period of time, including any time for treatment(s) and/or recovery.

From: _____ To: _____

☐ **Reduced Schedule.** Due to the condition, it is medically necessary for the employee to work a reduced schedule.

From: _____ To: _____

The Employee is able to work: _____
(e.g., 5 hours/day, up to 25 hours a week)

☐ **Intermittent Leave.** Due to the condition, it is medically necessary for the employee to be absent from work on a periodic basis, including for any episodes of incapacity *i.e.*, episodic flare-ups. Provide your best estimate of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, absences on an **intermittent basis** are estimated to occur:

_____ ☐ Day / ☐ Week / ☐ Month and are likely to last approximately

_____ ☐ hours / ☐ days per episode.

☐ **Planned Medical Appointments.** Due to the condition, the employee will have planned medical appointments on the following dates:

_____

☐ **Referrals.** The Employee was referred to another healthcare provider for evaluation / treatment.

Referral Specialty: _____

Start Date: _____ Estimated End Date: _____

Referral Specialty: _____

Start Date: _____ Estimated End Date: _____

EMPLOYEE LAST NAME:_____

PART D: JOB FUNCTIONS

Please complete this Part based on the Job Functions / Job Description provided in Section I. If no Job Functions / Job Description are provided, answer these questions based upon the employee's own description of their job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be **not able** to perform the essential job functions of the position during the absence for treatment(s).

Due to the Employee's condition, they ☐ are / ☐ are not able to perform one or more of their job functions. Please list at least one function the employee is unable to perform.

_____

_____

_____

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PART D: ADDITIONAL INFORMATION

_____

_____

_____

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_____

PART E: SIGNATURE

_____ _____

Signature of Health Care Provider Date

_____

Printed Name and Title