Reset Form

Certification of Health Care Provider for Family Member'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**	

SECTION II – FOR COMPLETION BY THE EMPLOYEE

The State of Maine's Primary Family and Medical Leave Policy and Family and Medical Leave Policy for Employees Taking Leave for a Grandchild with a Serious Health Condition (Collectively, "FMLA Policies") requires that an employee seeking Family Medical Leave (FML) because of a need to care for a covered family member with a serious health condition submit a medical certification issued by the health care provider of the covered family member.

Please complete Section II before giving this form to your family member or their medical provider. The FMLA Policies require that you submit a timely, complete, and sufficient medical certification to support a request for leave to care for a covered family member with a serious health condition. Your response is required to obtain or retain the benefit of the FMLA Policies 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 to your HR Representative.** Please contact your HR Representative with any questions.

Name of Family Member	Date of Birth (If Child or Grandchild)

Relationship of Family Member (Select Relationship)

☐ Spouse ☐ Domestic Partner ☐ Parent ☐ Child ☐ Sibling ☐ Grandchild

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

_____

_____

_____

_____

_____

_____ _____

Signature of Employee Date

SECTION III – FOR COMPLETION BY THE HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA Policies to care for your patient. Please 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 estimates based upon your medical knowledge, experience, and examination and medical knowledge of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA Policies coverage. Limit your responses to the condition for which the employee needs 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's Name

Approximate Date Condition Commenced	Probable Duration of the Condition

For FMLA to apply, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient (e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort).

_____

_____

_____

PART B: MEDICAL FACTS (CONTINUED)

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: _____

☐ **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 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.

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):

_____

_____

_____

_____

PART C: AMOUNT OF LEAVE NEEDED

Check all that Apply:

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

From: _____ To: _____

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

_____

(CONTINUED ON NEXT PAGE)

PART C: AMOUNT OF LEAVE NEEDED (CONTINUED)

☐ **Intermittent Leave.** Due to the condition, it is medically necessary for the employee to be absent from work on a periodic basis to provide care to the patient, 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.

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

Referral Specialty: _____

Start Date: _____ Estimated End Date: _____

Referral Specialty: _____

Start Date: _____ Estimated End Date: _____

PART D: ADDITIONAL INFORMATION

PART E: SIGNATURE

_____ _____

Signature of Health Care Provider Date

_____

Printed Name and Title