Certification of Health Care Provider for Employee's Serious Health Condition
Family and Medical Leave Policy for Employees of Maine State Government

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Policy for Employees of Maine State Government (FMLPMSG) 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 health care provider. Please complete Section I before giving this form to your employee. You may not ask the employee to provide more information that what is covered in this form. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FML purposes as confidential medical records in separate files/records from the usual personnel file and in accordance with state and federal law and regulations.

Employer name and contact:_____

Employee's job title:_____

Employee's essential job functions:_____

_____

Date form provided to employee:_____

Check if job description is attached:____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLPMSG 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 FMLPMSG 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.

Your name:_____
First Middle Last

Regular work schedule_____TAMS ID#_____

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLPMSG. 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 FMLPMSG coverage. Limit your responses to the condition for which the employee is seeking leave. 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.

Provider's name and business address:_____

Type of practice / Medical specialty:_____

Telephone:(___)_____Fax:(___)_____

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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 so, 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 so, state the nature of such treatments and expected duration of treatment:
   _____

2. Is the medical condition pregnancy? __No __Yes. If so, expected deliverey date:_____

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

   Is the employee unable to perform any of his/her job functions due to the condition: __No__Yes.

   If so, identify the job functions the employee is unable to perform:
   _____

4. 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):
   _____
   _____
   _____
   _____
   _____
   _____
   _____

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PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery?__No __Yes.

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

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? __No __Yes.

   If so, are the treatments or the reduced number of hours of work medically necessary?
   __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:

   _____

   Estimate the part-time or reduced work schedule the employee needs, if any:

   _____hour(s) per day; _____days per week from_____through_____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? __No __Yes.

   Is it medically necessary for the employee to be absent from work during the flare ups? __No __Yes. If so, explain:

   _____

   _____

   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)___month(s)

   Duration:___hours or ___day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER

CONTINUED ON NEXT PAGE

Signature of Health Care Provider **Date**

PRINTED NAME AND TITLE