

Certification of Health Care Provider for  
Family Member's Serious Health Condition  
under the Family and Medical Leave Act

U.S. Department of Labor  
Wage Hour Division

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR .  
RETURN TO THE PATIENT.

OMB Control Number: 1235-0003  
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The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave to care for a family member with a serious health condition to submit a medical certification issued by the family member's health care provider. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee at least 15 calendar days to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.311. Information about the FMLA may be found [on the WHD website at www.dol.gov/agencies/whd/fmla](http://www.dol.gov/agencies/whd/fmla)

SECTION I - EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. Do not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.305, 825.308.

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employee when the employee was an employer. An employer may also take FMLA leave if the employer has assumed the obligations of a parent. No legal or biological relationship

Employee Name: \_\_\_\_\_

(3) Briefly describe the care you will provide to your family member (Check all that apply)

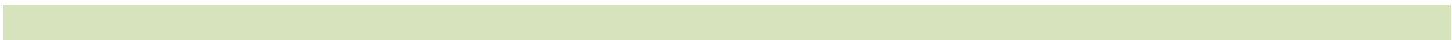
Assistance with basic medical, hygienic, nutritional, or safety needs      Transportation  
Physical Care      Psychological Comfort      Other: \_\_\_\_\_

(4) Give your best estimate of the amount of leave needed to provide the care described: \_\_\_\_\_

(5) If a reduced work schedule is necessary to provide the care described, give your best estimate of the reduced schedule you are able to work. From \_\_\_\_\_ (mm/dd/yyyy) to \_\_\_\_\_ (mm/dd/yyyy) I am able to work \_\_\_\_\_ (hours per day) \_\_\_\_\_ (days per week)

Employee

Signature: \_\_\_\_\_



\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



