Family Medical Leave and Disability Services
516 High Street, MS 9054
Bellingham, WA 98225-5996
Phone: (360) 650-3771
Confidential Fax: (360) 788-0071

Medical Certification – Family Member

Please complete Section I before giving the form to your health care provider. You are responsible for ensuring Human Resources receives timely and sufficient medical documentation in order to obtain or retain FMLA leave protections to care for your family member with a serious health condition. Failure to provide complete and sufficient medical certification may result in denial of your FMLA request. **Please return this form within 15 calendar days to Human Resources, not your supervisor.**

Section I: For Completion by the EMPLOYEE	
Employee Name:	Name of Family Member:
Relationship of Family Member:	If child, date of birth:
Describe the care you will provide to your family member:	
Employee Signature	Date

Section II: For Completion by the HEALTH CARE PROVIDER		
Our employee has requested leave under the FMLA to care for a family member who is your patient. 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 FMLA coverage. Limit your responses to the condition for which the patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Please be sure to sign the form on the last page.		
Approximate date condition began:	Probable duration of condition:	Dates you treated patient for condition:
Provide relevant medical facts related to the condition (include symptoms, diagnosis, frequency of doctor visits or any regimen of continuing treatment such as the use of specialized equipment):		
Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? If yes, dates of admission:		❑ Yes ❑ No
Will the patient need to have treatment visits at least twice per year due to the condition?		❑ Yes ❑ No
Was medication, other than over-the-counter medication, prescribed?		❑ Yes ❑ No
Was your patient referred to other health care provider(s) for evaluation or treatment? If yes, describe the nature and expected duration of the treatments:		❑ Yes ❑ No

AMOUNT OF LEAVE 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.

Full-Time Leave

Will the patient be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ❑ Yes ❑ No

If yes, estimate the period of incapacity: Start Date: _____ End Date: _____

During this time, will the patient need care? ❑ Yes ❑ No

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

Part -Time or Intermittent Leave

Will the patient require follow-up treatments, including any time for recovery? ❑ Yes ❑ No
If yes, describe the anticipated treatment schedule and treatment recovery period:

Will the condition cause episodic flare-ups that prevent your patient from participating in normal activities? ❑ Yes ❑ No

Does the patient need care during flare-ups? ❑ Yes ❑ No

Will the patient require care on an intermittent or part-time basis, including any time for recovery? ❑ Yes ❑ No

Estimate the duration and frequency of care needed for treatments and/or flare-ups of related incapacity:

Duration: _____ hours or _____ day(s) per episode

Frequency: _____ times per _____ day(s) or per _____ week(s) or _____ month(s)

Estimated dates care will be needed: Start Date: _____ End Date: _____

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

Health Care Provider Name	**Signature**	**Date**
Address	**City, State, Zip**	
Type of Practice	**Phone**	**Fax**

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.

Send completed form to confidential fax at (360) 788-0071.