SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees’ family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer name and Contact: MIT Disabilities Services and Medical Leaves Office; tel: (617)253-4572 or (617)324-0082, email: hr-dsmlo@mit.edu, confidential fax: (617)253-1502

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: ___________________________________________________________
First Middle Last MIT ID

Name of family member for whom you will provide care: ____________________________
First Middle Last

Relationship of family member to you: __________________________________________

If family member is your son or daughter, date of birth: ____________________________

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

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Employee Signature __________________________ Date ____________________________

Please also read and sign The Genetic Information Nondiscrimination Act of 2008 (GINA) section on page 4
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 to care for your patient. 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 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. Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider’s name and business address: ____________________________________________________________

Type of practice / Medical specialty: _____________________________________________________________

Telephone: (___) ____________________ Fax: (___) ____________________

PART A: MEDICAL FACTS

1. Approximate date condition commenced: __________________________________________________________

   Probable duration of condition: _________________________________________________________________

   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: ________________________________________________________________ Was medication, other
   than over-the-counter medication, prescribed? ___No ___Yes.

   Will the patient need to have treatment visits at least twice per year due to the condition? ___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 delivery date: __________________________

3. 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):

   ______________________________________________________________________________________

   ______________________________________________________________________________________

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PART B: AMOUNT OF CARE 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:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery?  ____No  ____Yes.

Estimate the beginning and ending dates for the period of incapacity: _____________________________

During this time, will the patient need care?  ____No  ____Yes.

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

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

5. Will the patient require follow-up treatments, including any time for recovery?  ____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:

________________________________________________________________________________________

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

________________________________________________________________________________________

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?  ____No  ____Yes

Estimate the hours the patient needs care on an intermittent basis, if any:

_______ hour(s) per day; _______ days per week  from ________________ through ________________

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

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________
7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities?  ___No  ___Yes.

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

Does the patient need care during these flare-ups?  ___ No  ___ Yes.

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

ADDITONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Signature of Health Care Provider
Date

The Genetic Information Nondiscrimination Act of 2008 (GINA)
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.

Employee Signature
Date