

**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. § 825.313. 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. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308.** Additionally, you 825pot





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

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

Provide your **best estimate** of the beginning date: \_\_\_\_\_ (mm/dd/yyyy) and end date \_\_\_\_\_ (mm/dd/yyyy) for the period of incapacity.

- (10) Due to the condition it, ( was / is / will be) medically necessary for the employee to be absent from work to provide care for the patient on an **intermittent basis** (periodically), 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, episodes of incapacity are estimated to occur \_\_\_\_\_ times per ( day / week / month) and are likely to last approximately \_\_\_\_\_ ( hours / days) per episode.

**Signature of Health Care Provider** \_\_\_\_\_ **Date** \_\_\_\_\_ (mm/dd/yyyy)

Definitions
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