County of Loudoun, VA
Certification of Health Care Provider
Employee/Family Member Serious Health Condition
Family and Medical Leave Act of 1993 – "FMLA"

To be completed by the treating physician and submitted to Benefits / Human Resources.

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.

Employer Name: **County of Loudoun, VA**

Send Completed Forms to: **Barbara Wooten, Human Resources / Benefits**
1 Harrison St SE, MSC 41A
Leesburg, VA 20177
(703) 771-5970 (571) 258-3212 (fax)

Check the certification type below:
- ☐ **New**
- ☐ **Response to 15-day Notice**
- ☐ **Update/Recertification**

SECTION I: Requires completion by the EMPLOYEE

Instructions: Please complete this section before giving this form to your medical provider. It is your responsibility to submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition, or that of a covered family member with a serious health condition for which you must provide care. This information contained herein is required to obtain or retain the benefit of FMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your leave request.

1. Employee's Name: _____
2. Job Title: _____ Regular Work Schedule: _____
3. Essential Job Functions: _____

   _____

   Check if job description / performance plan is attached: ( )
4. Name of family member for whom you will provide care: _____
   a. Relationship of family member to you: _____
   b. If family member is your son or daughter, date of birth: _____
   c. Describe care you will provide to your family member and estimate leave needed to provide care: _____

_____

_____

_____

_____

_____ _____
Employee Signature Date

SECTION II: Must be completed by the HEALTH CARE PROVIDER

Instructions: The above employee has requested leave under FMLA. Please 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 employee is seeking leave. Page 3 provides space for additional information, should you need it. Please write legibly, print or type your responses.

Provider's Name & Business Address_____

Telephone and Fax: _____ Type of practice / Medical specialty: _____

SECTION III: Must be completed by the HEALTH CARE PROVIDER – MEDICAL FACTS

Part A: Complete for all patients

1. Approximate date condition commenced:_____
2. Probably duration of condition:_____
3. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? _____

   ( ) No ( ) Yes If so, dates of admission: _____
4. Date(s) you treated the patient for condition: _____
5. Will the patient need to have treatment visits at least twice per year due to the condition? ( ) No ( ) Yes
6. Was medication, other than over-the-counter medication, prescribed? ( ) No ( ) Yes
7. 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: _____

   _____
8. Is the medical condition pregnancy? ( ) No ( ) Yes If so, expected date of delivery: _____
9. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptom, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

   _____

   _____
10. Will the patient be incapacitated for a single continuous period of time due to his/her medical condition, included any time for treatment and recovery? ( ) No ( ) Yes

    a. If so, estimate the date for the period of incapacity: beginning date_____ through_____
11. Will the patient need to attend follow-up treatments / appointments, including any time for recovery? ( ) No ( ) Yes

    a. Are the treatments /appointments medically necessary? ( ) No ( ) Yes

    b. If so, does this require the employee to work on a ( ) intermittent or ( ) reduced hour basis? ( ) No ( ) Yes
12. Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

    _____

    _____

13. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities (including performing his/her job functions)? ( ) No ( ) Yes

   a. During this time, will the patient need care? ( ) No ( ) Yes

   b. 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 six (6) months (e.g. 1 episode every 3 months lasting 1-2 days):

      Frequency: _____ times per ( ) week ( ) month

      Duration Per Episode: _____hours _____days

Part B: Complete only if employee is your patient - the following questions should be answered based upon the employee's own description of his/her job functions unless additional information such as a job description has been provided. ( ) No ( ) Yes

1. Is the employee unable to perform any of his/her job functions due to the condition: ( ) No ( ) Yes

   a. If so, identify the job function(s) the employee is unable to perform: _____

   _____

Part C: Complete only if patient is a family member of the employee – 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 o physical or psychological care:

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

   _____

   _____

2. Will care be required on a ( ) full-time, ( ) intermittent or ( ) reduced hour basis?

   a. If so, estimate the hours needed to provide care:

   _____ hour(s) per day; _____days per week

   beginning _____ through _____

Part D: Additional information: Identify question number with your additional answer.

_____

_____

SECTION IV*: Certification of Health Care Provider*

_____ _____

Signature of Health Care Provider Date

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[1]The information sought on this form relates only to the condition for which the employee is taking FMLA leave.

[2]"Incapacity" for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery there from.

[3]"Treatment" includes examinations to determine if a serious health condition exists and evaluations of the condition. "Treatment" does not include routine physical examinations, eye examinations, or dental examinations.