**CERTIFICATION OF HEALTH CARE PROVIDER FOR**
**FAMILY MEMBER'S SERIOUS HEALTH CONDITION (FAMILY AND MEDICAL LEAVE ACT)**
**GEAUGA COUNTY ALTERNATIVE TO WH-380-F**

**SECTION I: INSTRUCTIONS to the EMPLOYER:**

Geauga County requires 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. Complete **Section I** before giving this form to your Employee. 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 maintain records and documents relating to medical certifications, re-certifications, or medical histories of employees' family members, created for FMLA purposes as confidential medical records in separate files/records from 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:_____
Employee Requesting LOA: _____
Employee's job title: _____ Regular work schedule: _____
Date this form was provided to the employee: _____

**SECTION II: INSTRUCTIONS to the EMPLOYEE:**

Complete **Section II** before giving this form to your family member or his/her medical provider. Geauga County requires 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. 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. 29 C.F.R. § 825.305. You have until _____ (at least 15 calendar days) to return this form to your employer. Your Health Care Provider may return this form directly to your employer with your authorization at the address on the last page of this form.

PRINT YOUR NAME _____
First Middle Last

_____ _____
EMPLOYEE SIGNATURE DATE

PRINT Name of family member for whom you will provide care:_____
First Middle Last
Relationship to you: _____ Spouse; _____ Son or _____ Daughter or _____ Parent (____ Mother ____ Father)

If family member is your son or daughter, date of birth:_____
Eligibility of son or daughter: Must be under the age of 18 or if older than 18, incapable of self-care because of a mental or physical disability at the time FMLA is requested.

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

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SECTION III: INSTRUCTIONS to the HEALTH CARE

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. Last page provides space for additional information, should you need it. Please be sure to sign the form and return it to the Employee or to the address provided on the last page of this form.

**PART A: MEDICAL FACTS**

Approximate date condition commenced: _____
Probable duration of condition: _____

**Mark below as applicable:**

1. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? _____No_____Yes If yes, 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 yes, 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):

_____
_____

**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. If 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. If 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 If 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 If yes, explain the care needed by the patient, and why such care is medically necessary: _____
_____
_____

**ADDITIONAL INFORMATION:** IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____
_____
_____
_____
_____
_____
_____

(Please use the reverse of this form or attach additional pages)

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| | |
|---|---|
| **Signature of Health Care Provider** | **Date** |
| **Printed Name of Health Care Provider** | **Type of Practice** |
| | **Telephone Number** |
| **Address of Health Care Provider** | **Facsimile Number** |

WITH EMPLOYEE AUTHORIZATION, THE HEALTH CARE PROVIDER MAY RETURN THIS FORM DIRECTLY TO:

Kathleen K. Hostutler
Geauga County Commissioners
470 Center Street, Building #4
Chardon, Ohio 44024

khostutler@co.geauga.oh.us
440-279-1672 Phone
440-279-1317 Direct Fax

**PHYSICIAN:** If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT**

**Genetic Information Nondiscrimination Act (GINA) FMLA Certification Disclosure**

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.

Eff. 1/16/09, GINA added 1/1/12