Lincoln Financial Group®

Certification of Health Care Provider for Employee's Serious Health Condition Family and Medical Leave Act (FMLA)

Leave Services
P.O. Box 8700,
Dover, NH 03821-8700
Phone: 1-888-685-1372
Fax: 1-866-265-9028

SECTION I: TO BE COMPLETED BY PATIENT/EMPLOYEE

INSTRUCTIONS TO THE EMPLOYEE: Please complete Section I before providing this form to your health care provider. The FMLA permits an employer to require that you submit a medical certification to support a request for FMLA leave. Failure to timely provide a complete and sufficient medical form will result in a denial of your FMLA Request.

Company Name: _____

Employee Name: _____ **Leave ID#:**

Employee Date of Birth: _____ **Employee Phone: (_____)** _____

Employee Job Title: _____

Employee Regular Work Schedule: Shift Begin Time: _____ **Shift End Time:** _____

Regular Days Worked: ☐Sunday ☐ Monday☐ Tuesday ☐ Wednesday ☐Thursday ☐ Friday ☐ Saturday

Work Schedule Comments: _____

_____

Note: If you need a part time or a consistent reduced work schedule, it is your responsibility to provide this information to your employer in order for them to plan accordingly.

Leave Begin Date: _____**Leave End Date:** _____

Medical Release: I authorize the release and verification of medical information in order to process this FMLA request.

Signature of Patient/Employee: _____ **Date:** _____

_____

SECTION II: TO BE COMPLETED BY A QUALIFIED HEALTH CARE PROVIDER

INSTRUCTIONS TO THE HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Please answer all questions so a determination for FMLA coverage can be made.

For residents of California, do not disclose the underlying diagnosis unless you have received consent from the patient.

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 Name: _____ **Leave ID#:**

SECTION II CONTINUED: TO BE COMPLETED BY A QUALIFIED HEALTH CARE PROVIDER

1. MEDICAL FACTS: *This may include symptoms, diagnosis or any regimen of continuing treatment, such as the use of specialized equipment.*

(1A) Other than residents of CA, describe the patient's medical facts (symptoms/diagnosis) related to the serious health condition:

_____

_____

(1B) Approximate Date condition commenced: _____ Probable duration of condition: _____

If the medical condition is **pregnancy**, provide the expected delivery date: _____

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2. TREATMENT: This includes examinations to determine if a serious health condition exists, evaluations of the condition and actual treatment by or under the supervision of a qualified health care provider.

(2A) Was the patient seen within 7 days of the requested leave begin date? ☐ YES ☐ NO

(2B) Was medication, other than over-the-counter medication, prescribed? ☐ YES ☐ NO

(2C) Will the patient need to have treatment visits at least twice per year due to the condition? ☐ YES ☐ NO

(2D) Was the patient admitted for an overnight stay in a hospital, hospice, or medical care facility? ☐ YES ☐ NO

If yes: Admission Date: _____ Discharge Date: _____

(2E) Was the patient referred to another health care provider(s) for evaluation or treatment? ☐ YES ☐ NO

If yes, Provider Name:_____

Provider Specialty: _____

Provider Phone Number: (_____) _____

Describe the nature of the treatment: _____

_____

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3. ABSENCE FROM WORK: Please refer to the list of the patient's job description if one has been provided. If one has not been provided, please answer this question based on the patient's own description of his/her job function.

(3A) Is the patient unable to perform any of his/her job functions due to his/her serious health condition? ☐ YES ☐ NO

If yes, identify the job functions patient is unable to perform:

_____

_____

_____

(3B) Is it medically necessary for patient to be absent from work? ☐ YES ☐ NO

If yes, specify the appropriate reason(s) below. **Select <u>ALL</u> that apply.**

☐ Due to Incapacity (The employee may need time off work due to experiencing episodic flare-ups)

☐ Due to Treatment/Visits (The employee may need time off to attend appointments)

Employee Name: **Leave ID#:**

SECTION II CONTINUED: TO BE COMPLETED BY A QUALIFIED HEALTH CARE PROVIDER

4. LEAVE DATES/FREQUENCY: For an extension of a leave, there should be no gap in time from the end date shown on page 1 and begin date provided.

(4A) Will the patient be incapacitated and absent from work for a single continuous period of time? ☐ YES ☐ NO

If yes: Leave Begin Date: _____ Leave End Date: _____

(4B) Will the patient need recurring absences taken at separate periods of time? ☐ YES ☐ NO

If yes: Leave Begin Date: _____ Leave End Date: _____

Frequency: Based on your medical knowledge, experience and examination of the patient, please estimate a frequency. If unsure, a reasonable range should be provided. Terms such as "n/a", "unknown", "undetermined" or "as needed" are not acceptable.

i. Frequency for Incapacity:

a) Number of episodes: _____ per ☐ Week OR ☐ Month

b) How many hours, days or weeks per episode?

_____ Hour(s) _____ Day(s) _____ Week(s)

ii. Frequency for Treatment/Visits:

Number of Appointments: _____ per ☐ Week OR ☐ Month

(4C) Is it medically necessary for the employee to work a part-time or a consistent reduced work schedule due to the patient's health condition? ☐ YES ☐ NO

If yes, specify below, including time and duration for the reduced work schedule: (Example: Cannot work more than 5 hours a day for one month)

_____

_____

I certify that the information provided in this Certification of Health Care Provider form (Section II) is accurate to the best of my knowledge.

Signature of Provider: _____ Date: _____

Print Provider Name: _____ Phone: (_____)_____

Provider Medical Specialty: _____

Medical Credentials (Example: MD, DO, ***DC**): _____ Fax: (_____)_____

***IF** the medical credential is listed as "**DC**", please confirm if x-rays have been taken for the patient's condition. ☐ YES ☐ NO

Please **FAX** the completed Certification of Health Care Provider form to Lincoln Financial Group. Retain a copy of the form AND the successful fax confirmation report for your records. If you wish to mail or contact Lincoln Financial Group, the information is provided at the top of page one.