



***Family Medical Leave (FML)
Certification of Health Care Provider***

(To be completed by your physician/provider)

- The attached Certification of Health Care Provider MUST be returned by the due date provided on your FML Eligibility Notice. For most employees this Eligibility notice will be sent via email.
- If the Certification of Health Care Provider is not received by the DUE DATE given in your Eligibility Notice, Family Medical Leave will be denied.
- The Certification of Health Care Provider is also used for Non-FMLA Medical Leaves.
- You must submit a Leave of Absence request form in addition to this Certification of Health Care Provider in order for your leave request to be processed.

Note: To qualify for Family Medical Leave, an employee must have worked for Denver Health for one year and have worked at least 1,250 hours in the past 12 months.

Please return your paperwork promptly. A delay in returning your forms will result in either a delay or denial of FML.

Return all FML paperwork via fax or scanning to email to:

**Employee Relations Department
660 Bannock Street, Denver, CO 80204**

FAX: 303-602-4944

EMAIL: LOAFMLProcess@dhha.org

**If you have questions regarding FML paperwork,
please call 303-602-7007.**

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

SECTION I: EMPLOYEE TO COMPLETE

INSTRUCTIONS to the EMPLOYEE: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to the employee's own serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Sections I before giving this form to your medical provider. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. You have 15 calendar days (from the date the Leave of Absence Request Form is submitted) to return this form to the Denver Health Employee Relations Department.

Employer Name: Denver Health and Hospital Authority

Contact: Employee Relations, 303-602-7007

The following information is necessary for all leave requests:	
Employee's job title:	
Regular work schedule:	
Employee's essential job functions:	Check if job description is attached: <input type="checkbox"/>

Employee Name: _____
First
Middle
Last

Employee Signature

Date

SECTION II: EMPLOYEE TO COMPLETE FOR A COVERED FAMILY MEMBER LEAVE

INSTRUCTIONS to the EMPLOYEE: Please complete Sections I and 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. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. You have 15 calendar days (from the date the Leave of Absence Request Form is submitted) to return this form to the Denver Health Employee Relations Department.

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, provide their date of birth:	
Describe care you will provide to your family member and estimate leave needed to provide care:	

SECTION III: HEALTH CARE PROVIDER TO COMPLETE

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above or your patient has requested leave under the FMLA. 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 or patient is seeking leave. Please be sure to sign the form on the last page.

Provider's name:	
Provider's business address:	
Type of practice / Medical specialty:	
Telephone:	Fax:

PART A: MEDICAL FACTS

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

Mark below as applicable:

Was the employee/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 employee/patient for condition: _____

Will the patient need to have treatment visits at least twice per year due to the condition? No Yes.

Was medication, other than over-the-counter medication, prescribed? No Yes.

Was the employee/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. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition: No Yes. If so, identify the job functions the employee is unable to perform:

4. Describe relevant medical facts of the condition for which the employee/patient seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

PART B: AMOUNT OF LEAVE NEEDED FOR EMPLOYEE'S OWN CONDITION.

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? No Yes.

If yes, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? No Yes.

If so, are the treatments or the reduced number of hours of work medically necessary? <input type="checkbox"/> No <input type="checkbox"/> Yes.
Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:
Estimate the part-time or reduced work schedule the employee can work, if any: _____ hour(s) per day; _____ days per week from _____ through _____.

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? No Yes.

Is it medically necessary for the employee to be absent from work during the flare-ups? <input type="checkbox"/> No <input type="checkbox"/> Yes.
If yes, explain:
Based upon the patient's medical history and your knowledge of the medical condition, estimate (use your best guess) 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

PART C: AMOUNT OF LEAVE NEEDED FOR COVERED FAMILY MEMBER WITH A SERIOUS HEALTH CONDITION.

When answering these questions for a Covered Family Member, 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:

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

If yes, estimate the beginning and ending dates for the period of incapacity:
During this time, will the patient need care? <input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, explain the care needed by the patient and why such care is medically necessary:

9. 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:

10. 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:

11. 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 (**use your best guess**) 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 below.

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Signature of Health Care Provider

Printed Name of HCP

Date

****This document will not be accepted without provider signature and date.****

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting 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.