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

U.S. Department of Labor
Wage and Hour Division

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 8/31/2021

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require 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. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, 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 generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: DHS/FEMA, 500 C St SW, Washington, DC 20024, Jacqueline Gause, MSc

Texas Recovery Office Houston, TX Mobile: 202-322-6241

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section 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. 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. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: Max J Meindl
First Middle Last

Name of family member for whom you will provide care: Rachel P Meindl
First Middle Last

Relationship of family member to you: Spouse

If family member is your son or daughter, date of birth: _____

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

Currently in critical condition, 50% mortality rate, previously undetected diabetes, blood poisoning,

Sepsis is a life-threatening condition in which the body is fighting a severe infection that has spread via the bloodstream,

low potassium contributing to heart conditions.

Employee Signature 03/11/2020
Date

CONTINUED ON NEXT PAGE

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: 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. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: Gay C Christoph MD, 235 W Palm St # 102, Bellville, TX 77418

Type of practice / Medical specialty: Family Medicine

Telephone: (979) 865-8484 Fax:( )

PART A: MEDICAL FACTS

1. Approximate date condition commenced: 10 mar 20

Probable duration of condition: -

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
___No __(Yes. If so, dates of admission: 10 mar 20

Date(s) you treated the patient for condition: 10 mar 20 to present

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 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. 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):

Sepsis

DKA

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: 10 mar 20 - 24 may 20

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

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

   Pt. has high risk of Death

5. 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:

   initially 1-2 x/month

   Explain the care needed by the patient, and why such care is medically necessary:

   Severe DM

6. 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:

   8 hour(s) per day; 2 days per week from mar 20 through Dec 20

   Explain the care needed by the patient, and why such care is medically necessary:

   Debility from Severe Illness

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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: 2 times per 1 week(s) _____ month(s)

Duration: 4 hours or ___ day(s) per episode

Does the patient need care during these flare-ups? ____ No ___(Yes.)

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

Monitoring for uncontrolled Diabetes

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

Signature of Health Care Provider **Date** 11 Mar 20

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

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. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210.
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