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| DOTLOGOMISSOURI DEPARTMENT OF TRANSPORTATION CERTIFICATION FOR FAMILY MEMBER’S SERIOUS HEALTH CONDITION FAMILY AND MEDICAL LEAVE ACT (FMLA) LEAVE |

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| **SECTION I**: For completion by **MoDOT Human Resources** (*complete prior to giving form to employee*) | | |
| Employer name and contact: | |  |
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| **SECTION II**: For completion by the **Employee** | | | | |
| Please read and complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits MoDOT 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. 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 must provide the completed medical certification (or an explanation of why you have been unable to obtain the completed medical certification) within 15 calendar days. | | | | |
| Your full name: | |  | | |
| Full name of family member for whom you will provide care: | | | |  |
| Relationship of family member to you: | | |  | |
| 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: | | | | |
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| **Employee Signature** |  | **Date** |

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| **SECTION III**: For completion by the **Health Care Provider** | | | | |
| The employee listed on the previous page 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. 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: | |  | | |
| Provider’s business address: | |  | | |
| Type of practice/medical specialty: | |  | | |
| Telephone: |  | | Fax: |  |

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| **PART A:** MEDICAL FACTS | | | | | | | | | | | | | | | | |
| 1. Approximate date condition commenced: | | | | | | | |  | | | | | | | | |
| 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, date(s) of admission: | | | | |  | | | | | | |
| Date(s) you treated the 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 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: | | | | | | | | | | |
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| 2. Is the medical condition pregnancy? | | | | | | | No | | Yes | | If so, expected delivery date: | | |  | | |
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| 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): | | | | | | | | | | | | | | | | |
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| **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 due to his/her medical condition, | | | | | | | | | | | | | | | | |
| including any time for treatment and recovery? | | | | | | | No | | Yes | | | | | | | |
| If so, estimate the beginning and ending dates for the period of incapacity: | | | | | | | | | | |  | | | | | |
| During this time, will the patient need care? | | | | | | No | | Yes | | | | | | | | |
| Explain the care needed by the patient and why such care is medically necessary: | | | | | | | | | | | | | |  | | |
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| 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: | | | | | | | | | | | | | | | | |
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| Explain the care needed by the patient and why such care is medically necessary: | | | | | | | | | | | | | |  | | |
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| 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: | | | | | | | | | | | | | | | | |
|  |  | hour(s) per day; | |  | days per week from | | | | |  | | | through | | |  |
| Explain the care needed by the patient and why such care is medically necessary: | | | | | | | | | | | | | |  | | |
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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: |  | | | times per |  | | week(s) | |  | | month(s) |
|  | Duration: |  | | | 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: | | | | | | | | | | |  | |
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| **ADDITIONAL INFORMATION:** IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER | |
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| **Signature of Health Care Provider** |  | **Date** |

Return completed form to the patient.

NOTE: The Genetic Information Nondiscrimination Act (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order 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.