STATE OF WEST VIRGINIA
MEDICAL LEAVE OF ABSENCE WITHOUT PAY and/or FEDERAL FAMILY and MEDICAL LEAVE ACT (FMLA)

Supplemental Certification of Health Care Provider for Employee's Serious Health Condition

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: This form should be required when Form DOP-L3 does not provide sufficient information. In accordance with the West Virginia Division of Personnel *Administrative Rule*, W. VA. CODE R. §143-1-1 *et seq*., and the Family and Medical Leave Act (FMLA), an employer may require an employee seeking leave and/or FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please 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 generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees 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.

Employer Name: ____ Contact Phone: __________________

Employee's Job Title: ______________________________ Regular Work Schedule: ___________________________

Employee's Essential Job Functions: ____

☐ Check if job description is attached.

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The *Administrative Rule* and FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own 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 leave request. 20 C.F.R. §825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. §825.305(b).

EMPLOYEE NAME: ____
First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the *Administrative Rule* of the Division of Personnel and/or 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 is seeking leave. Page 4 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

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.

Provider’s name and 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 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 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: ____

   ____

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 other relevant medical facts, if any, related to the condition for which the employee 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

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 so, estimate the beginning and ending dates for the period of incapacity:

   FROM: _______________ TO: _______________ (required)

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?
   ☐ 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:

   ____

   Estimate the part-time or reduced work schedule the employee needs, 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?
☐ No ☐ Yes If so, explain: ____
____
____

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

8. Patient was or may be able to resume full duty employment, with no restrictions in work activities, on ______________________________.

If unable to presently return to full duty employment, can the patient return to less than full duty?
☐ No ☐ Yes

If yes, what is the period of partial incapacity? FROM _____________ TO _____________

Describe in detail any limitations or restrictions on the ability of the employee to work. List any assistive devices or equipment or any accommodation the employee requires to perform his/her job. Use reverse if necessary.

____
____
____
____

Will this condition permanently prevent the employee from performing his/her duties?
☐ No ☐ Yes

ADDITIONAL INFORMATION (Identify question number with your additional answer):

____
____
____
____
____
____
____
____

___________________________________ ___________________________________
Signature of Health Care Provider Date