STATE OF WEST VIRGINIA
FEDERAL FAMILY and MEDICAL LEAVE ACT (FMLA) and/or STATE PARENTAL LEAVE ACT (PLA)

Supplemental Certification of Health Care Provider for Family Member'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. The federal Family and Medical Leave Act (FMLA) and West Virginia Parental Leave Act (PLA) provide 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. 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 and PLA 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 and contact: ____

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 or her medical provider. The FMLA and PLA permit an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for 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 and/or PLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your leave request. Your employer must give you at least 15 calendar days to return this form to your employer.

Your name: ____
First Middle Last

Name of family member for whom you will provide care: ______________________________
First Middle Last

Relationship of family member to you: ______________________
Relationship

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:

______________________________ ______________________
Employee Signature Date

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 and/or PLA 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/PLA coverage. Limit your responses to the condition for which the patient needs 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. **Family medical history is required only to the extent necessary to make the medical certification complete and sufficient under FMLA.**

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 (required):____

   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: ____

   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):

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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, including any time for treatment and recovery? ☐ No ☐ Yes

   Estimate the beginning and ending dates for the period of incapacity:

   FROM: ______________________ TO: ______________________ (required)

   During this time, will the patient need care? ☐ No ☐ Yes

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

   ____
   ____
   ____
   ____
   ____

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: ______________________
   ____

   Explain the care needed by the patient, and why such care is medically necessary:
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   ____
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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   From Date: ___________________________

   ______ days per week   Through Date: ___________________________

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

   ____
   ____
   ____
   ____

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:

   ____
   ____
   ____
   ____

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

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____
____

____   ______________________
Signature of Health Care Provider   Date