Waterman, Robert - WHD

From: Danelle Knight <dknight@naipta.az.gov>
Sent: Thursday, August 15, 2019 2:12 PM
To: WHDPRAComments
Cc: Danelle Knight
Subject: WH-380F
Attachments: WH-380-F Draft Revision FINAL.pdf

Whom it may concern,

I like the changes that you have made to this form. I appreciate that you have added the due date that would be found on the Notice of Rights.

I like that you have added information about parent or child in loco parentis and what that means. In addition, the check boxes for the type of activities that would need to be performed for the individual and time table.

I appreciate the check boxes added to make it simpler for medical providers to complete.

Thank you

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Certification of Health Care Provider for Serious Health Condition of the Family Member
(Family and Medical Leave Act)
U.S. Department of Labor
Wage and Hour Division

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

OMB Control Number: 1235-0003
Expires: xx/xx/20xx

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 family member with a serious health condition to submit a medical certification issued by the family member's health care provider. 29 C.F.R. § 825.305. If requested by the employer, the medical certification is required for the leave to be FMLA-protected. 29 U.S.C. §§ 2613, 2614(c)(3). The employer must give the employee **at least 15 calendar days**, absent unusual circumstances, to provide the certification. If the employee is unable to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at http://www.dol.gov/whd/fmla.

SECTION I - EMPLOYER

Please complete this section before giving this form to your employee.

(1) Employee name: _____
First *Middle* *Last*

(2) Employer name: _____ Date: _____
(List date certification requested from the employee)

(3) On _____ *(date)*, we learned of your need for leave beginning on _____ *(date)* for the health condition of your family member.

(4) The medical certification must be returned by _____, absent unusual circumstances.
(List date the certification is due, which must be at least 15 days from the date the certification is given to the employee)

SECTION I - EMPLOYER INSTRUCTIONS

Please complete Section I before giving this form to your employee. Your response is voluntary. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308**. Additionally, you **may not** request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees or 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.

Employee Name: _____

SECTION II - EMPLOYEE

The FMLA allows an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of your family member. If requested by your employer, your response is required to obtain or retain the benefit of the FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). **You are responsible for making sure the medical certification is provided to your employer within the time frame requested, which must be at least 15 calendar days, absent unusual circumstances.** 29 C.F.R. §§ 825.305-825.306. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA leave request. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at http://www.dol.gov/whd/fmla.

Please complete and sign Section II before giving this form to your family member or his/her health care provider.

(1) Name of the family member for whom you will provide care:

_____

(2a) Identify the relationship of the family member to you:
(Select as appropriate)

- ☐ Spouse
- ☐ Parent, including *in loco parentis*
- ☐ Child, including *in loco parentis*

(*In loco parentis* refers to a relationship in which a person assumes the obligations of a parent to a child. This means that an employee may take FMLA leave to care for an individual who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a child for whom the employee has assumed the obligations of a parent.)

(2b) If the family member is your son or daughter, provide the date of birth: _____

(3a) Briefly describe the care you will provide to your family member:
(Select as appropriate)

- ☐ Assistance with basic medical, hygienic, nutritional, or safety needs
- ☐ Transportation
- ☐ Physical Care
- ☐ Psychological Comfort
- ☐ Other: _____

(3b) Give your **best estimate** of the amount of leave needed to provide the care described: _____

_____

(4) If a **reduced work schedule** is necessary to provide the care described, give your **best estimate** of the reduced work schedule you need:

Starting date _____ Ending date _____
Hour(s) per day _____ Day(s) per week _____

Employee Signature _____ ***Date*** _____

Employee Name: _____

SECTION III - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form below. See page 4 for additional instructions.

Health Care Provider's name: *(Print)* _____

Health Care Provider's business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax: (_____) _____

E-mail address: _____

PART A: Medical Information

Limit your response to the medical condition for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). Several questions seek a response as to the amount of time, as it relates to how often (the frequency) or how long (the duration) is needed for treatment, care, related incapacity, and/or recovery of a serious health condition of the patient. Be as specific as you can; terms such as "*lifetime*," "*unknown*," or "*indeterminate*" may not be sufficient to determine if the benefits and protections of the FMLA apply.

(1) Patient's Name: _____

(2) State the approximate date the condition started or will start: _____

(3) Provide your **best estimate** of how long the condition lasted or will last: _____

_____

(4) For FMLA to apply, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient (*e.g.*, assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort). _____

_____

For the questions below, check the box indicating appropriate medical information.

(Select the appropriate category – see page 6 for definitions of these terms)

☐ (5a) Inpatient Care

The patient ☐ has been / ☐ is expected to be admitted for **an overnight stay** in a hospital, hospice, or residential medical care facility. List the date(s) of admission:

_____

_____

(5b) **Beyond the overnight stay**, the patient ☐ has been / ☐ is expected to be incapacitated from

_____ to _____

Employee Name: _____

☐ (6a) Incapacity Plus Treatment
The patient ☐ has been / ☐ will be **incapacitated** from
_____ to _____
due to his/her medical condition.

(6b) Due to the condition, the patient ☐ was / ☐ will be seen on the following date(s):

_____

_____

(6c) Medication, other than over-the-counter medication, ☐ has been / ☐ will be prescribed.

☐ (7) Pregnancy
The condition is **pregnancy**. State the expected delivery date: _____

☐ (8) Chronic Conditions
Due to the condition, it is medically necessary for the patient to have **treatment visits at least twice per year**.

☐ (9) Permanent or Long Term Conditions *(e.g., Alzheimer's disease, the terminal stages of cancer)*
Due to the condition, incapacity is **permanent or long term** and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ (10) Conditions Requiring Multiple Treatments (*e.g., chemotherapy, restorative surgery after an accident)* Due to the condition, it is medically necessary for the patient to receive **multiple treatments** on: _____

_____

(11) Briefly describe other appropriate medical facts, if any, related to the condition of the patient for which the employee seeks FMLA leave. _____

_____

PART B: Amount of Leave Needed

Provide your best estimate of the amount of additional leave, not otherwise captured in Part A, needed for treatment, care, and/or recovery of the patient.

(Select as appropriate)

☐ (1) Due to the condition, the patient ☐ was / ☐ will be **incapacitated for a continuous period of time** due to his/her medical condition, including any time for treatment and recovery. Estimate the beginning and end date for the period of incapacity: _____

_____

☐ (2) Due to the condition, the patient ☐ had / ☐ will have **planned medical treatment(s)** on: *(e.g., prenatal appointments)* _____

_____

Employee Name: _____

☐ (3a) Due to the condition, the patient ☐ was / ☐ will be **referred to other health care provider(s)** for evaluation or treatment. State the nature of such treatments: *(e.g., physical therapy)*

_____

_____

(3b) Provide your **best estimate** of the duration of the treatment(s), including any recovery period:

_____

_____

☐ (4) Due to the condition, the patient ☐ required / ☐ requires / ☐ will require care on an **intermittent basis** (periodically), including for any foreseeable or unforeseeable episodes of incapacity *(i.e., episodic flare-ups)*.

Provide your **best estimate** of how long (the duration) and how often (the frequency) the intermittent episode(s) will last *(e.g., 2 hours each episode, 1 time per week)*.

Amount of Time (Duration)	**How Often (Frequency)**
_____ Hour(s)	_____ Per Day
_____ Day(s)	_____ Per Week
_____ Week(s)	_____ Per Month
_____ Month(s)	_____ Per Year

Signature of Health Care Provider _____ **Date** _____

SECTION III - HEALTH CARE PROVIDER INSTRUCTIONS

A family member of your patient has requested leave under the FMLA to care for your patient. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a family member with a serious health condition. 29 C.F.R. §§ 825.305-825.306. If the employer requests medical certification, the employee is responsible for providing a complete and sufficient certification, generally **at least 15 calendar days** after the employer's request. Information about the FMLA may be found on the WHD website at http://www.dol.gov/whd/fmla.

You also may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment.

Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

Employee Name: _____

The chart below provides the definition of a serious health condition under the FMLA.

Definition of a Serious Health Condition
Inpatient Care
• An overnight stay in a hospital, hospice, or residential medical care facility. • Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.
Continuing Treatment by a Health Care Provider (any one or more of the following)
Incapacity Plus Treatment A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: ○ Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, ○ At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
Pregnancy Any period of incapacity due to pregnancy or for prenatal care.
Chronic Conditions Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
Permanent or Long-term Conditions A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.
Conditions Requiring Multiple Treatments • Restorative surgery after an accident or other injury; or, • A condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the employee or employee's family member did not receive the treatment.

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 15 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 Avenue, N.W., Washington, D.C. 20210.

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