Waterman, Robert - WHD

From: Danelle Knight <dknight@naipta.az.gov>
Sent: Thursday, August 15, 2019 1:24 PM
To: WHDPRAComments
Cc: Danelle Knight
Subject: WHD380E
Attachments: WH-380-E Draft Revision FINAL.pdf

To whom it may concern:

I appreciate that you have added the section to the top of the document that addresses when the employee notified the employer about the medical condition that would normally be found on the Notice of Rights. This allows all of the information to be is one place. The employee knows when the form must be returned. At the top of the page.

I would like to see a check box added Essential Functions. This would provide the option to attach rather than list a brief statement.

I appreciate the simplicity changes that were made to the form to aide the medical providers in completing the form.

I appreciate the added section regarding Essential function and requirement of the medical provider to sign the document.
The addition of the definition of what a serious health conditions is for the employee is great.

Thank you for taking the time to make these changes.

Danelle Knight
Employee Relations Generalist, SHRM-SCP, MBA
Mountain Line
3773 N. Kaspar Dr., Flagstaff, AZ 86004
W: 928.679.8926
FAX: 928.779.6868
www.mountainline.az.gov

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

U.S. 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 due to a serious health condition to submit a medical certification issued by the employee'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 the 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 your own health condition.

(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)

(5a) Employee's job title: _____

(5b) Job description ☐ is / ☐ is not attached

(6) Employee's regular work schedule: _____

(7) Statement of the employee's essential job functions: _____

_____

_____

(The essential functions of the employee's position are to be determined with reference to the position the employee held at the time notice is given or leave started, whichever is earlier)

Employee Name: _____

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 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.

SECTION II - 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 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 employee. 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) State the approximate date the condition started or will start: _____

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

_____

Employee Name: _____

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

(Select the appropriate category. See page 6 for definitions of these terms.)

☐ (3a) 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 _____
_____

(3b) **Beyond the overnight stay**, the patient ☐ has been / ☐ is expected to be incapacitated from _____ to _____

☐ (4a) Incapacity Plus Treatment
The patient ☐ has been / ☐ is expected to be **incapacitated** from _____ to _____ due to his/her medical condition.

(4b) Due to the condition, the patient ☐ **was** / ☐ will be seen on the following date(s): _____
_____

(4c) Medication, other than over-the-counter medication, ☐ has been / ☐ will be prescribed.

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

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

☐ (7) Permanent or Long Term Conditions *(e.g. Alzheimer's disease or 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).

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

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

Employee Name: _____

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)* _____

_____

☐ (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, ☐ it was / ☐ it is / ☐ will be medically necessary for the employee to be absent from work 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 leave episode(s) will likely 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

☐ (5) Due to the condition, it is medically necessary for the employee to work on a **reduced schedule basis**. Provide your best estimate of the reduced work schedule the employee needs:

Starting date _____ Ending date _____

Hour(s) per day _____ Day(s) per week _____

Employee Name: _____

PART C: Essential Job Functions

Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a statement 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. An employee who must be absent from work to receive medical treatment for a serious health condition is considered to be not able to perform the job functions of the position during the absence for treatment.

☐ The employee ☐ **was not able** / ☐ **is not able** / ☐ **will not be able** to perform *one or more* of his / her job function(s) due to the health condition. Identify at least one job function the employee is not able to perform:

_____

_____

☐ The employee ☐ **was able** / ☐ **is able** / ☐ **will be able** to perform *all* of his / her job function(s).

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

SECTION II - HEALTH CARE PROVIDER INSTRUCTIONS

Your patient has requested leave under the FMLA. 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 due to the employee's own 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 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.

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