TAXATION & REVENUE NEW MEXICO

CERTIFICATION OF HEALTH CARE PROVIDER EMPLOYEE'S SERIOUS HEALTH CONDITION (FMLA) [Non-fillable version (fill out by hand)]

Section One

INSTRUCTIONS to the EMPLOYEE: Please complete Section I before giving this form to your medical provider. The FMLA allows us 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. The completion of the paperwork is 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 your FMLA request not being approved. [29 C.F.R. § 825.313.] You have 15 calendar days to return this form. [29 C.F.R. § 825.305.]

Your name: _____

First | Middle | Last | Employee ID (SHARE ID)

Section Two

For Completion by the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer fully and completely all applicable parts below. Several questions seek an answer regarding the frequency or duration of a condition and/or treatment. 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 three (3) provides space to add more information should you need it. Please be sure to sign and date the form on the last page.

Provider's name (please print): _____ Type of practice/medical specialty: _____

Provider's business address: _____

Telephone: _____ Fax: _____

Part A: Medical Facts

1. Approximate date condition commenced: Date: _____

Probable duration of condition: _____

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? No ☐ Yes ☐
If **YES**, date(s) of admission: _____

Date(s) you treated the patient for condition: Date(s): _____

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 **YES**, what was the nature of the evaluation or treatment(s)? _____

And the expected duration of treatment(s)? _____

2. Is the medical condition pregnancy? No ☐ Yes ☐
If **YES**, expected delivery date: _____

3. Does the condition prevent the employee from performing some of their job functions? *(If the essential functions have not been provided by the employer, you may answer based on the employee's own description of their job functions.)*
No ☐ Yes ☐ If **YES**, 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 Care Needed—Continuous FMLA

5. Will the employee be incapacitated for a single continuous period of time due to their medical condition, including any time for treatment and recovery? No ☐ Yes ☐
If **YES**, estimate the beginning and ending dates for the period of incapacity: _____

6. Will the condition cause episodic flare-ups periodically preventing the employee from performing their job functions?
No ☐ Yes ☐
Is it medically necessary for the employee to be absent from work during the flare-ups? No ☐ Yes ☐
If YES, explain:

_____

_____

Based upon the patient's medical history and your knowledge of the medical condition, ***estimate*** the ***approximate*** 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: _____ time per week **OR** _____ per month
Duration: _____ hour(s) **OR** _____ day(s) per episode

Part C: Amount of Care Needed—Intermittent FMLA

7. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of their medical condition? No ☐ Yes ☐

If **YES**, estimate treatment schedule, if any, and include:

Date of Appointment	Time Required	Recovery Period

Estimate the part-time or reduced work schedule the employee needs, if any:

_____ hour(s) per day; _____days per week from: _____through: _____

Additional Information: Identify question number with your additional answer.

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