CUNY The City University of New York

FAMILY AND MEDICAL LEAVE ACT (FMLA)
CERTIFICATION OF HEALTH CARE PROVIDER FOR FAMILY MEMBER'S SERIOUS HEALTH CONDITION

FMLA FORM-3 B

Section 1: TO BE COMPLETED BY EMPLOYER

College | Address

City | State | Zip Code | Tel. | FAX

Name of Employee | Empl. ID | Department

Section II: INSTRUCTIONS TO EMPLOYEE

FMLA permits CUNY to require that you submit a timely, complete and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by CUNY, your response is required to obtain or retain the benefits of FMLA protections. Failure to provide a complete and sufficient medical certification may result in denial of your FMLA request.

Please complete this section and attach the CERTIFICATE OF FAMILY RELATIONSHIP FORM before giving this form to your family member or his/her Health Care Provider.

CUNY gives you at least 15 calendar days to return this form.

This form must be returned by

CERTIFICATE OF FAMILY RELATIONSHIP FORM MUST BE ATTACHED

Name of family member for whom you will provide care

Describe care to be provided by you

Estimate leave needed

Section III: INSTRUCTIONS TO HEALTH CARE PROVIDER

The employee listed above has requested leave under the FMLA to care for your patient.
- 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 patient needs care.
- Do not provide information about genetic tests, genetic services, or the manifestation of disease or disorder in the employee's family members.

PLEASE PRINT CLEARLY OR TYPE. SIGN THE FORM ON THE LAST PAGE (Page 4)

Health Care Provider's Name _____ Tel.: _____ FAX _____

Address _____

City _____ State _____ Zip Code _____ Country _____

Type of Practice / Medical Speciality

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PART A: MEDICAL FACTS

Approximate date condition commenced _____ Probable duration of condition _____

Answer as applicable

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ☐ Yes ☐ No

If yes, dates of admission From Date _____ To Date _____

Dates you treated the patient for condition _____

Will the patient need to have treatment visits at least twice per year due to the condition? ☐ Yes ☐ No

Was medication, other than over-the-counter medication, prescribed? ☐ Yes ☐ No

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ☐ Yes ☐ No

If yes, state the nature of such treatments and expected duration of treatment:

Is the medical condition pregnancy? ☐ Yes ☐ No If yes, expected date of delivery _____

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

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.

Will the patient be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ☐ Yes ☐ No

If yes, estimate the beginning and end dates for the period of incapacity: From date _____ To date _____

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

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

Will the patient require follow-up treatments, including any time for recovery? ☐ Yes ☐ No

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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PART B: AMOUNT OF CARE NEEDED *(continued)*

Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? ☐ Yes ☐ No

Estimate the hours the patient needs care on an intermittent basis, if any

Hour(s) per day _____ Days per week _____

From date _____ To date _____

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

Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ☐ Yes ☐ No

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., one episode every 3 months lasting 1-2 days):

Frequency No. of times per week _____ No. of times per month _____

Duration No. of hours per episode _____ No. of day(s) per episode _____

Does the patient need care during these flare-ups? ☐ Yes ☐ No

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

ADDITIONAL INFORMATION:

IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER

PRINT NAME OF HEALTH CARE PROVIDER _____

SIGNATURE OF HEALTH CARE PROVIDER _____

LICENSE # _____ **DATE** _____