

**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 \_\_\_\_\_

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

**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

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

---

**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

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

---

**ADDITIONAL INFORMATION:**

IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER

---

**PRINT NAME OF HEALTH CARE PROVIDER**

**SIGNATURE OF HEALTH CARE PROVIDER**

**LICENSE #**

**DATE**