Certification of Health Care Provider for Employee's Serious Health Condition: MEDICAL CERTIFICATION for the Americans With Disabilities Act (ADA), Pregnancy And Other Leave Laws

U.S. Department of Labor Wage and Hour Division

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The ADA and other leave laws state that an employer may require an employee seeking leave protections due to a serious health condition to submit a medical certification issued by the employee's health care provider. Providing a complete and sufficient medical certification is required to obtain or retain any potential benefits under the ADA, Pregnancy and other legal protections and requested leaves. Your employer must give you approximately 15 calendar days to return this form.

SECTION I – EMPLOYER

Either the employee or the employer may complete Section I. 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.

(1) Employee name: _____

(2) Employer name: _____ Date: _____ *(mm/dd/yyyy)*

(List date certification requested)

(3) **The medical certification must be returned by** _____ *(mm/dd/yyyy)*

The employee may be denied their leave and legal protections if this document is not fully completed and returned by its due date.

(4) Employee's job title: _____ Job description (☐is / ☐is not) attached.

Employee's regular work schedule:

_____

Statement of the employee's essential job functions (See attached Job Description, if provided.) :

_____

_____

_____

SECTION II - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient has requested legal protections under the ADA and potentially other legal coverages. The ADA and other leave laws allow an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for ADA and other types of leave due to the serious health condition and/or disability of the employee.

Employee Name: _____

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

Health Care Provider's business address: _____

Type of practice / Medical specialty: _____

Telephone: (___) _____ Fax: (___) _____ E-mail: _____

PART A: Medical Information

Limit your response to the medical condition(s) for which the employee is seeking leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.**

(1) Briefly describe the employee's diagnosis and/or condition: _____
_____

(2) State the approximate date the condition started or will start: _____ *(mm/dd/yyyy)*

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

(4) What limitations will be placed on the employee's ability to work? (i.e., Talk on the phone? Problem solve? Address and resolve conflict? Handle stressful situations?) Please state for what period of time for each limitation.
_____
_____

(5) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

- ☐ **Inpatient Care**: The patient (☐has been / ☐is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____

- ☐ **Incapacity plus Treatment**: *(e.g. outpatient surgery, strep throat)*
  Due to the condition, the patient (☐has been / ☐is expected to be) incapacitated for *more than* three consecutive, full calendar days from _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*.
  The patient (☐was / ☐will be) seen on the following date(s): _____
  _____
  The condition (☐has / ☐has not) also resulted in a course of continuing treatment under the supervision of a health care provider *(e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment)*

- ☐ **Pregnancy**: The condition is pregnancy. List the expected delivery date: _____ *(mm/dd/yyyy)*.

- ☐ **Chronic Conditions**: *(e.g. asthma, migraine headaches)* Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

- ☐ **Permanent or Long Term Conditions**: *(e.g. Alzheimer's, 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).

- ☐ **Conditions requiring Multiple Treatments**: (*e.g. chemotherapy treatments, restorative surgery)* Due to the condition, it is medically necessary for the patient to receive multiple treatments.

- ☐ **None of the above**: If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

Employee Name: _____

(6) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks leave or might need a reasonable accommodation. *(e.g., use of nebulizer, dialysis*)

_____

PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. 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 your eligibility for legal protection coverage.

(1) Due to the condition, the patient (☐ had / ☐will have) **planned medical treatment(s)** (scheduled medical visits) *(e.g. psychotherapy)* on the following date(s): _____

_____

(2) Due to the condition, the patient (☐was / ☐will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: *(e.g. cardiologist, physical therapy)* _____

Provide your **best estimate** of the beginning date _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery *(e.g. 3 days/week)*

_____

(3) Due to the condition, is it medically necessary for the employee to work a **reduced schedule?** _____ Provide your **best estimate** of the reduced schedule the employee is able to work. From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)* the employee is able to work: *(e.g., 5 hours/day, up to 25 hours a week)*

_____

(4) Due to the condition, the patient (☐was / ☐will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the period of incapacity.

(5) Due to the condition, it (☐was / ☐is / ☐will be) medically necessary for the employee to be absent from work on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur _____ times per ☐ day / ☐week / ☐month) and are likely to last approximately _____ (☐hours / ☐ days) per episode.

Employee Name: _____

PART C: Essential Job Functions

If provided, the information in Section I question #4 may be used 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 the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be ***not able*** to perform the essential job functions of the position during the absence for treatment(s).

(1) Due to the condition, the employee (☐was not able / ☐is not able / ☐will not be able) to perform *one or more* of the essential job function(s). Identify the essential job functions from the attached job description employee was/is/will not be able to perform and state for how long.

_____

_____

_____

(2) Will employee need any reasonable accommodations to perform their job, in particular these essential functions? If so, please list and state how long these reasonable accommodations will be needed.

_____

_____

_____

_____

Signature by health care provider affirms that all of the information in this document is true and accurate to his/her/ their professional ability. (Sign below)

Health Care Provider _____ Date _____ (mm/dd/yyyy)

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