Appendix B
Certification of Health Care Provider for Employee’s Serious Health Condition
(Family and Medical Leave Act)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

OMB Control Number: 1215-0181
Expires: XXXXXX

SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: 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. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to 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.

Employer name and contact:

Employee’s job title: ________________________ Regular work schedule: ________________________

Employee’s essential job functions:

________________________________________

Check if job description is attached: ______

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer 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. If requested by your employer, your response is required 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 a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: ________________________________

First Middle Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. 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 employee is seeking leave. Please be sure to sign the form on the last page.

Provider's name and business address: ________________________________

Type of practice / Medical specialty: ________________________________

Telephone: (______) ___________________ Fax: (______) ________________

Page 1 CONTINUED ON NEXT PAGE

Form WH-380-E November 2008

All documents are to be returned to Human Resources attn: Karyn Jeffrey. Carleton College, One North College Street, Northfield, MN 55057 Phone: 507-222-4174; Fax: 507-222-7788
PART A: MEDICAL FACTS

1. Approximate date condition commenced: ________________________________

   Probable duration of condition: ________________________________

   Mark below as applicable:
   Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?  
   ____No  ____Yes. If so, dates of admission:

   ________________________________

   Date(s) you treated the patient for condition:

   ________________________________

   Will the patient need to have treatment visits at least twice per year due to the condition?  ____No  ____Yes.

   Was medication, other than over-the-counter medication, prescribed?  ____No  ____Yes.

   Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?  
   ____No  ____Yes. If so, state the nature of such treatments and expected duration of treatment:

   ________________________________

2. Is the medical condition pregnancy?  ____No  ____Yes. If so, expected delivery date: ________________________________

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to 
   provide a list 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.

   Is the employee unable to perform any of his/her job functions due to the condition:  ____No  ____Yes.

   If so, 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 LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ___Yes.

If so, estimate the beginning and ending dates for the period of incapacity: ________________________.

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee’s medical condition? ___No ___Yes.

If so, are the treatments or the reduced number of hours of work medically necessary?
___No ___Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

________________________________________

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

__________ hour(s) per day; __________ days per week from __________ through __________

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ___No ___Yes.

Is it medically necessary for the employee to be absent from work during the flare-ups? ___No ___Yes. If so, explain:

________________________________________

________________________________________

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

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or ____ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER:

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

Page 3

CONTINUED ON NEXT PAGE

Form WH-380-E November 2008
Signature of Health Care Provider  Date

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 20 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 Ave., NW, Washington, DC 20210.  DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.

Page 4  Form WH-380-E  November 2008