



**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

**Certification of Health Care Provider for Employee's Serious Health Condition  
(Family and Medical Leave Act)**

Policy #: To be assigned.  
Rev. Date:

**ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.**

\_\_\_\_\_  
**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.**

**Notification to Healthcare Providers**

Title II of the Genetic Information Nondiscrimination Act (GINA) “prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. ‘Genetic information,’ as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic test, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.”

**Additional Notification Relating to Pregnancy and Employment:**

Employees, as defined in SB 212, shall be free from discrimination in relation to pregnancy, childbirth, and related conditions, including the right to reasonable accommodation to known limitations related to pregnancy, childbirth and related conditions pursuant to Title 19 of the Delaware Code, Chapter 7. See, 19 Delaware Code Section 711(a)(3).

For Agency Use Only	
Date Issued to Employee:	
Date Returned by Employee:	
Date Approved:	
Date Denied:	
Date Returned to Employee for additional information:	
Reviewed by:	