CERTIFICATION OF HEALTH CARE PROVIDER FOR
EMPLOYEE'S SERIOUS HEALTH CONDITION (FAMILY AND MEDICAL LEAVE ACT)
GEAUGA COUNTY ALTERNATIVE TO WH-380-E

SECTION I: INSTRUCTIONS to the EMPLOYER

When insufficient certification is provided by the employee, Geauga County requires 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. Complete **Section I** before giving this form to your Employee. 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 maintain records and documents relating to FMLA as confidential medical records in separate files/records from 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: _____
Date this form was provided to the employee: _____
Employee Requesting LOA: _____
Employee's job title: _____ Regular work schedule: _____
Employee's essential job functions: _____
_____

_____ Check if job description is attached. _____ Check if Job Analysis is attached.

SECTION II: INSTRUCTIONS to the EMPLOYEE

Complete **Section II** before giving this form to your medical provider. Geauga County requires that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. 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. 29 C.F.R. § 825.313. You have until _____ (at least 15 calendar days) to return this form to your employer. Your Health Care Provider may return this form directly to your employer with your authorization at the address on the last page of this form.

PRINT YOUR NAME: _____
First Middle Last
SIGNATURE: _____

SECTION III: 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 and return it to the employee or mail or fax it to the address provided on the last page of this form.

PART A: MEDICAL FACTS

Approximate date condition commenced: _____
Probable duration of condition: _____

Mark below as applicable:

1. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
___No ___Yes. If yes, dates of admission: _____

CERTIFICATION OF HEALTH CARE PROVIDER FOR
EMPLOYEE'S SERIOUS HEALTH CONDITION (FAMILY AND MEDICAL LEAVE ACT)
GEAUGA COUNTY ALTERNATIVE TO WH-380-E

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

2. Is the medical condition pregnancy? ___No ___Yes. If yes, 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 yes, 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 yes, 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 yes, 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 yes, explain: _____
_____
_____

CERTIFICATION OF HEALTH CARE PROVIDER FOR
EMPLOYEE'S SERIOUS HEALTH CONDITION (FAMILY AND MEDICAL LEAVE ACT)
GEAUGA COUNTY ALTERNATIVE TO WH-380-E

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.

_____
_____
_____
_____
_____
_____

(Please use the reverse of this form or attach additional pages)

_____ _____
Signature of Health Care Provider **Date**

_____ _____
Printed Name of Health Care Provider **Type of Practice**

_____ _____

_____ **Telephone Number**

_____ _____
Address of Health Care Provider **Facsimile Number**

WITH EMPLOYEE AUTHORIZATION, THE HEALTH CARE PROVIDER MAY RETURN THIS FORM DIRECTLY TO:

Kathleen K. Hostutler
Geauga County Commissioners
470 Center Street, Building #4
Chardon, Ohio 44024

khostutler@co.geauga.oh.us
440-279-1672 Phone
440-279-1317 Direct Fax

PHYSICIAN: 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. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT**

Genetic Information Nondiscrimination Act (GINA) FMLA Certification Disclosure

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. **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 tests, 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.

Eff. 1/16/09, GINA added 1/1/12 update 1/12/2017