Certification of Health Care Provider for Family Member's Serious Health Condition Family and Medical Leave (FML)

TO BE COMPLETED BY THE EMPLOYER

INSTRUCTIONS TO THE EMPLOYER: The Navajo Nation Personnel Policy Manual (NNPPM) Section X.D. provides that an employer may require an employee seeking FML protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete this section before giving this form to your employee. The Department of Personnel Management maintain records and documents relating to medical certifications and re-certifications of employees for FML purposes as confidential medical records in a separate file.

Employer name and contact:_____

TO BE COMPLETED BY THE EMPLOYEE

INSTRUCTIONS TO THE EMPLOYEE: Please complete this section before giving this form to your family member or his/her medical provider. The FML permits an employer to require that you submit a timely, complete and sufficient medical certification to support your request for FML to care for a covered family member with a serious health condition. Your employer must give you at least 15 calendar days to return this form.

Employee name: _____
(First) (Middle) (Last)

Name of family member for whom you will provide care:_____
(First) (Middle) (Last)

Relationship of family member to you:_____

If family member is your son or daughter, date of birth:_____

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____

_____

_____ _____
Employee's Signature Date

TO BE COMPLETED BY THE HEALTH CARE PROVIDER

INSTRUCTIONS TO THE HEALTH CARE PROVIDER: The employee listed above has requested leave under FML to care for your patient. Please answer, fully and completely all applicable parts. Several questions seek a response as to the duration of a condition, treatment, etc. Be as specific as you can. Limit your response to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider'sname and business address:_____

Typeof practice/Medical specialty:_____

Telephone: _____ Fax: _____

PART A: Medical Facts

1. Approximate date condition commenced:_____

   Probable duration of condition:_____

   Was the patient admitted for an overnight stay in a hospital, hospices 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 years due to the condition? 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:_____

PART B: Amount of Leave Needed. When answering these questions, keep in mind 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:

3. Will patient require care on an intermittent or reduce schedule basis, including any time for recovery? No ☐ Yes ☐

   Estimate the hours the patient will need on an intermittent basis, if any:

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

_____ _____

Signature of Health Care Provider Date