GROUP BENEFIT SOLUTIONS

CLEAR FORM

NYL GBS Leave Solutions
Certification of Health Care Provider for Employee's Serious Health Condition

Date Prepared: _____ Must Be Returned By: _____

Employee Name: _____

Employer Name: _____

Notification Number: _____

Reason for requesting leave: _____

Leave date(s)/Period(s) requested: _____ through _____

Section I: For Completion by the Employee

INSTRUCTIONS to the EMPLOYEE: Please complete Section I 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. 29 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).If your certification is returned incomplete or insufficient, your employer must give you at least 7 calendar days to cure any deficiency. 29 C.F.R. § 825.305(c).

The Genetic Information Nondiscrimination Act of 2008 (GINA), and, where applicable, the California Genetic Information Nondiscrimination Act of 2011 (CalGINA), prohibits employers and other entities covered by GINA Title II, and where applicable CalGINA, from requesting or requiring genetic information of employees or their family members, except as specifically allowed by law. 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, unless failing to provide the information will result in an incomplete or insufficient certification. **(If the employee is seeking leave under the District of Columbia Family and Medical Leave Act, genetic information should not be provided under any circumstance.)** '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. "Genetic Information," as defined by CalGINA, includes information about the individual's or the individual's family member's genetic tests, information regarding the manifestation of a disease or disorder in a family member of the individual, and includes information from genetic services or participation in clinical research that includes genetic services by an individual or any family member of the individual. "Genetic Information" does not include information about an individual's sex or age.

*PLEASE BE SURE TO RETURN ALL PAGES

Employee Job Title: _____

Regular Work Schedule: _____

_____ _____

Employee Signature **Date**

See reverse to provide additional information

Section II: 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.

Subsection A: Must be completed for all types of leaves:

1. Provider's name: _____ Phone: _____ Fax: _____

   Address: _____ Email: _____

   Type of practice / Medical specialty: _____

Please complete the following:

2. Approximate date condition commenced: _____ Probable duration of condition: _____
3. Date(s) you treated the patient for condition in the past 12 months:

   _____
4. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

   ☐ No ☐ Yes

   If yes, dates of admission in the past 12 months: _____
5. Will the patient need treatment visits at least twice per year due to the condition? ☐ No ☐ Yes
6. Was medication, other than over-the-counter medication, prescribed? ☐ No ☐ Yes
7. Is the medical condition pregnancy? ☐ No ☐ Yes If yes, expected delivery date: _____
8. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☐ No ☐ Yes If yes, explain: _____
9. Is the employee unable to perform any of his/her job functions due to the condition based on the employee's own description of his/her job? ☐ No ☐ Yes

   If yes, identify the job functions the employee is unable to perform: _____
10. 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) **(Note: If the employee is requesting leave under the California Family Rights Act or the Connecticut Family and Medical Leave Act, do not include diagnosis information)**:

    _____

Subsection B: Must be completed for all continuous leaves:

1. 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:

   Start date: _____ End date: _____

(Form is considered incomplete/insufficient if not provided for a continuous leave)

Subsection C: Must be completed for all reduced scheduled leaves:

1. Is it **medically necessary** for the employee to work part-time or a reduced schedule because of the employee's condition? (this includes follow up treatment appointments) ☐ No ☐ Yes

   If yes, estimate the part-time or reduced work schedule the employee needs:

   ____ hour(s) per day ____ time(s) per week ____ time(s) per month Start date: _____ End date: _____

   (Form is considered incomplete/insufficient if not provided for a reduced/part-time leave)

Subsection D: Must be completed for all intermittent leaves:

1. Will the employee need intermittent time off? ☐ No ☐ Yes

   If yes, estimate the beginning and ending dates for the period the patient needs to be out of work:

   Start date: _____ End date: _____

2. **OFFICE VISITS/TREATMENTS:**
   Based upon the patient's medical history and your knowledge of the medical condition, estimate the maximum frequency of follow-up treatments/office visits that employee would need off work for related incapacity that the employee may experience over the next 6 months.

   (e.g. Duration: 3 hours per visit/treatment

   Frequency: 3 times per 1 ☐ week(s) / ☐ month(s) (check one)

   Duration:_____ hours per visit/treatment

   Frequency:_____ times per _____ ☐ week(s) / ☐ month(s) (check one)

   Form is considered incomplete/insufficient if not provided for an intermittent leave

3. **INCAPACITY:**
   Based upon the patient's medical history and your knowledge of the medical condition, estimate the maximum frequency of incapacity that employee would need off work over the next 6 months.

   (e.g. Duration: 3 hours per day or 2 days per episode

   Frequency: 3 times per 1 ☐ week(s) / ☐ month(s) (check one)

   Duration:_____ hours per day or _____ days per episode

   Frequency:_____ times per _____ ☐ week(s) / ☐ month(s) (check one)

   (Form is considered incomplete/insufficient if not provided for an intermittent leave)

ADDITIONAL INFORMATION

_____

_____ _____

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. The U.S. 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 AV, NW, Washington, DC 20210.

DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.

*PLEASE BE SURE TO RETURN ALL PAGES

Return completed certification form to:

NYL GBS Leave Solutions
Email: AbsenceManagement@newyorklife.com
Fax: 866.472.3221
P.O. Box 81077 Cleveland, OH 44181