World Wide Technology, Inc.

Certification of Health Care Provider for Family Member's Serious Health Condition under the Family and Medical Leave Act,

State and Company Leaves.

U.S. Department of Labor
Wage Hour Division

OMB Control Number: 1235-0003
Expires: 6/30/2026

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave to care for a family member with a serious health condition to submit a medical certification issued by the family member's health care provider. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I - EMPLOYEE

While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. **You may not be asked to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308**. Additionally, a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care may not be requested. Your Employer must generally maintain records and documents relating to medical information, medical certifications, recertifications, or medical histories of employees or employees' family members 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, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

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

(2) Employer name: _____ Date: _____ *(mm/dd/yyyy)*
(List date certification requested)

SECTION II - EMPLOYEE

Please complete and sign Section II before providing this form to your family member or your family member's health care provider. The FMLA allows an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of your family member. If requested by your employer, your response is required to obtain or retain the benefit of the FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). **You are responsible for making sure the medical certification is provided to your employer within the time frame requested, which must be at least 15 calendar days.** 29 C.F.R. §§ 825.305-825.306. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA leave request. 29 C.F.R. § 825.313.

(1) Name of the family member for whom you will provide care: _____

(2) Select the relationship of the family member to you. The family member is your:

☐ Spouse ☐ Parent ☐ Child, under age 18
☐ Child, age 18 or older and incapable of self-care because of a mental or physical disability
☐ Other (For State Leaves Only) *define relationship:* _____

Spouse means a husband or wife as defined or recognized in the state where the individual was married, including in a common law marriage or same-sex marriage. The terms "child" and "parent" include *in loco parentis* relationships in which a person assumes the obligations of a parent to a child. An employee may take FMLA leave to care for an individual who assumed the obligations of a parent to the employee when the employee was a child. An employee may also take FMLA leave to care for a child for whom the employee has assumed the obligations of a parent. No legal or biological relationship is necessary.

Employee Name:_____ **Employee ID:**_____

Employer:_____

(3) Briefly describe the care you will provide to your family member: (*Check all that apply)*

☐ Assistance with basic medical, hygienic, nutritional, or safety needs ☐ Transportation
☐ Physical Care ☐ Psychological Comfort ☐ Other: _____

(4) Give your best estimate of the amount of leave needed to provide the care described: estimated to occur _____ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ (☐ hours / ☐ days) per episode.

Employee Signature _____ **Date** _____ *(mm/dd/yyyy)*

SECTION III - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form below. A family member of your patient has requested leave under the FMLA to care for your patient. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a family member with a serious health condition. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that *involves inpatient care* or *continuing treatment by a health care provider.* For more information about the definitions of a serious health condition under the FMLA, see the chart at the end of the form. You also may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

Health Care Provider's name: *(Print)* _____

Health Care Provider's business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax: (____) _____ E-mail: _____

PART A: Medical Information

Limit your response to the medical condition for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

(1) Patient's Name: _____

(2) State the approximate date the condition started or will start: _____ *(mm/dd/yyyy)*

(3) Provide your **best estimate** of how long the condition lasted or will last: _____

(4) For FMLA to apply, care of the patient must be medically necessary. Briefly describe the type of care needed by the patient (*e.g., assistance with basic medical, hygienic, nutritional, safety, transportation needs, physical care, or psychological comfort).*

_____
_____
_____
_____

Employee Name:_____ **Employee ID:**_____

Employer:_____

(5) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

☐ **Inpatient Care**: The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____

☐ **Incapacity plus Treatment**: *(e.g. outpatient surgery, strep throat)*
Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for *more than* three consecutive, full calendar days from _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*.
The patient (☐ was / ☐ will be) seen on the following date(s): _____
_____
The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider *(e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment)*

☐ **Pregnancy**: The condition is pregnancy. List the expected delivery date: _____ *(mm/dd/yyyy)*.

☐ **Chronic Conditions**: *(e.g. asthma, migraine headaches)* Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Permanent or Long Term Conditions**: *(e.g. Alzheimer's, terminal stages of cancer)* Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Conditions requiring Multiple Treatments**: (*e.g. chemotherapy treatments, restorative surgery)* Due to the condition, it is medically necessary for the patient to receive multiple treatments.

☐ **None of the above**: If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

(6) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. *(e.g., use of nebulizer, dialysis)* Please Note: If this form is being used to certify the need for leave under the California Family Rights Act, California regulations prohibit the disclosure of the underlying diagnosis of the serious health condition involved without the consent of the patient._____
_____

PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. 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.

Continuous Leave:

(7) Due to the condition, the patient (☐was/☐will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.
Provide your **best estimate** of the beginning date _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/ yyyy)* for the period of incapacity.

Appointment Intermittent Leave:

(8) Due to the condition, the patient (☐had /☐will have) **planned medical treatment(s)** (scheduled medical visits) *(e.g., psychotherapy, prenatal appointments)* on the following date(s): _____

Frequency = ____# time(s) per ____week(s) or ____ month(s)
Duration = ____# hour(s) or ____days(s) per episode(s)
Begin date: ____/____/____ End date: ____/____/____
(Estimate dates if unknown)

Employee Name:_____ **Employee ID:**_____

Employer:_____

Flareup's Intermittent Leave

(9) Due to the condition, it (□was /□is /□will be) medically necessary for the employee to be absent from work on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups.
Over the next 6 months, episodes of incapacity are estimated to occur:

Frequency = ____# time(s) per ____week(s) or ____ month(s)
Duration = ____# hour(s) or ____days(s) per episode(s)
Begin date: ____/____/____ End date: ____/____/___
(Estimate dates if unknown)

Referral Intermittent Leave:

(10) Due to the condition, the patient (□was /□will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: *(e.g., cardiologist, physical therapy)* _____

Frequency = ____# time(s) per ____week(s) or ____ month(s)
Duration = ____# hour(s) or ____days(s) per episode(s)
Begin date: ____/____/____ End date: ____/____/____
(Estimate dates if unknown)

Reduced Schedule

(11 Due to the condition, it is medically necessary for the employee to work a reduced schedule.

Provide your **best estimate** of the reduced schedule the employee **is able to** work: _____

Frequency = ____# time(s) per ____week(s) or ____ month(s)
Duration = ____# hour(s) or ____days(s) per episode(s)
Begin date: ____/____/____ End date: ____/____/____

Health Care Provider Signatures Required

Healthcare Providers Signature_____

Credentials_____ Date:_____

1. Please Initial and Date beside any updates that were made.
2. Re-Sign and date below if updates have been made in response to a cure or re-certification.

Healthcare Provider's Signature_____

Credentials_____ Date:_____

Employee Name:_____ **Employee ID:**_____

Employer:_____

Definitions of a Serious Health Condition *(See 29 C.F.R. §§ 825.113-.115)*
Inpatient Care
☐ An overnight stay in a hospital, hospice, or residential medical care facility. ☐ Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.
Continuing Treatment by a Health Care Provider (any one or more of the following)
Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.
Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.
Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive treatment.

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 15 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 Avenue, N.W., Washington, D.C. 20210.

PLEASE SEND COMPLETED FORM TO THE BELOW ADDRESS OR FAX NUMBER.

WWT Leave Administration
PO Box 1806
Alpharetta, GA 30023-1806
Phone: 1-855-287-3420
Fax: 1-866-568-6444
Web: https://my.adp.com