NEW YORK LIFE GROUP BENEFIT SOLUTIONS

NYL GBS Leave Solutions
Certification for Health Care Provider
for Family Member's Serious Health Condition

Date Prepared: _____

Must Be Returned By: _____

Employee Name: _____

Employer Name: _____

Leave ID: _____

Reason for requesting leave: _____

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

SECTION I: For Completion by the EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section I before giving this form to your family member or his/her 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 to care for a covered family member with a 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*

Name of family member for whom you will provide care: _____

Relationship of family member to you: _____, If child, date of birth: _____

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

_____

_____

Employee Signature _____ **Date**_____

SECTION II: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. 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 patient needs leave. Page 3 provides space for additional information, should you need it. 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 _____ and phone #_____fax #_____
   Address_____ Email_____
   Type of practice / Medical specialty:_____

Please complete the following:

2. Approximate date condition commenced:_____ Expected Duration:_____

3. 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 _____

4. Date(s) you treated the patient for condition 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. 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:_____
   _____

8. Is the medical condition pregnancy? __No __Yes; If yes, expected delivery date: _____

9. 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) If this leave is to care for a child 18 years of age or older, please provide specific Activities of Daily Living the child may need assistance in performing (i.e. bathing, cooking, hygiene, taking public transportation, etc.). **(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)**:_____
   _____

***AMOUNT OF CARE NEEDED:** When answering these questions, keep in mind that 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: ***

Subsection B: Must be completed for all CONTINUOUS LEAVES:

1. Will the patient 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 _____

During this time, will the patient need care? ____No ____Yes If yes, explain the care needed by the patient and why such care is medically necessary:_____

_____

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

Subsection C: Must be completed for all REDUCED SCHEDULE LEAVES.

1. Is it **medically necessary** for the employee to work part-time or a reduced schedule because of the patient's condition? ___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_____

During this time, will the patient need care? _____No ____Yes If yes, explain the care needed by the patient and why such care is medically necessary:_____
_____

(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 employee 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) (**circle one**))

Duration: _____ hours per visit/treatment
Frequency: _____ times per _____ week(s) / month(s) (**circle 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) (**circle one**))

Duration: _____ hour(s) per day _____ days per episode
Frequency: _____ times per _____ week(s) / month(s) (**circle one**)

During this time, will the patient need care? _____No ____Yes If yes, explain the care needed by the patient and why such care is medically necessary: _____
_____

(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 P.O. Box 703509 Dallas, TX 75370
Fax: 866.931.5095
Email: FMLACertifications@newyorklife.com