

**MAINE FAMILY MEDICAL LEAVE - CERTIFICATION OF HEALTH CARE PROVIDER  
FOR EMPLOYEE'S SERIOUS HEALTH CONDITION**

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**SECTION I: EMPLOYER INFORMATION**

Employer:

Contact Name:

Phone:

Employee's job title:

Job description is attached

Employee's essential job functions:

Regular work schedule:

**SECTION 2: EMPLOYEE INFORMATION**

Employee Name:

Please print your name above before giving this form to your medical provider. Protected leave laws permit an employer to require that you submit a timely and complete medical certification that is sufficient to support a request for protected leave due to your own serious health condition. Your response is required to obtain or retain the benefits of protected leave. Failure to provide a complete and sufficient medical certification may result in a denial of your request for protected leave.

**You have 15 calendar days to return this form to the employer representative noted above.**

**SECTION 3: HEALTH CARE PROVIDER**

Your patient has requested leave under the Maine Family Medical Leave (MFML) statutes. Please answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition or treatment. 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 MFML coverage. Limit your responses to the condition for which the employee is seeking leave.

*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.*

Provider Name \_\_\_\_\_

Phone \_\_\_\_\_

Fax \_\_\_\_\_

Business Address \_\_\_\_\_

Type of Practice / Medical Specialty \_\_\_\_\_

*Please be sure to sign the form on the last page.*

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**PART A: MEDICAL FACTS**

1. Approximate date condition commenced \_\_\_\_\_
  
2. Probable duration of condition \_\_\_\_\_
  
3. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?  No  Yes – Dates of admission \_\_\_\_\_
  
4. Date(s) you treated the patient for condition \_\_\_\_\_
  
5. Will the patient need to have 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 therapy)?  No  Yes - State the nature and expected duration of treatments:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  
8. Is the patient donating an organ for an organ transplant?  No  Yes
  
9. Is the medical condition pregnancy?  No  Yes - expected delivery date \_\_\_\_\_
  
10. 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.
  - a. Is the employee unable to perform any of his/her job functions due to the condition?  
 No  Yes - identify the job functions the employee is unable to perform  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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4. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions?  No  Yes
5. Is it medically necessary for the employee to be absent from work during the flare-ups?  
 No  Yes - explain:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
6. 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).
- a. Frequency: \_\_\_\_\_ times per \_\_\_\_\_ week(s) \_\_\_\_\_ month(s)
- b. Duration: \_\_\_\_\_ hours or \_\_\_\_\_ day(s) per episode

**PART C: ADDITIONAL INFORMATION**

Please identify the question number with your additional answers.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PART D: SIGNATURE**

\_\_\_\_\_  
Signature of Health Care Provider

\_\_\_\_\_  
Date