Certification of Health Care Provider
Family Member's Serious Health Condition

(Family and Medical Leave Act)

Clear Form

THE HARTFORD

Section I - For Completion by Employee: Complete the Employee Information section, sign page 3, and give it to your family member's health care provider to complete. Have your family member's provider return the completed form to you. You will need to return this form to The Hartford no later than 15 days from the date you requested your leave.

Forms can be mailed to: Hartford Leave Management
P. O. Box 14285
Lexington, KY 40512-4285

OR faxed to: Toll Free Fax: (877) 588-4817

This form must be returned no later than: _____

Employee Information

Employee's name:	Last 4 digits of Social Security Number:
Leave ID:	
Employer's name:	Family member's date of birth:
Today's date:	

Name of family member for whom you will be providing care:

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

Section II - For Completion by the Health Care Provider: (See Part A and Part B attached)

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. 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.

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 the manifestation of disease or disorder in family members of the individual, 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's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Provider's name:

Provider's Business Address:

Type of Practice/Medical Specialty:

Telephone Number: ( )

Fax Number: ( )

Employee's name: Leave ID:

PART A - Medical Facts (For Completion by the Health Care Provider)

Approximate date condition commenced:	Probable duration of condition:

1) Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
☐ No ☐ Yes If so, dates of admission: _____ _____ _____ _____

2) Date(s) you treated the patient in your office for condition:
_____ _____ _____ _____

3) Will the patient need to have treatment visits at least twice per year due to the condition? ☐ No ☐ Yes

4) Was medication, other than over-the-counter medication, prescribed? ☐ No ☐ Yes

5) 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.

6) Is the medical condition pregnancy? ☐ No ☐ Yes If so, expected delivery date: _____

7) If the patient is a dependent child age 18 or older, is the patient unable to perform three or more Activities of Daily Living or Instrumental Activities of Daily Living? ☐ Yes ☐ No

8) Provide the Medical Facts that support your certification. Such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment as the use of specialized equipment. ***(Note: Do not include diagnosis information for employees/patients who work in CT, ME, or RI).***

Employee's name: Leave ID:

PART B: 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.

1) Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ☐ No ☐ Yes

Estimate the beginning and ending dates for the period of incapacity: From _____ Through _____

During this time, will the patient need care? ☐ No ☐ Yes

2) Will the patient require follow-up treatments, including any time for recovery? ☐ No ☐ Yes

3) Estimate treatment/appointment schedule, if any, over the next 6 months including any recovery period:

Treatment/Appointment Frequency: _____ times per _____ week(s) or _____ month(s)

Treatment/Appointment Duration: _____ hours or _____ days(s) per treatment/appointment

Dates of scheduled treatment(s)/appointment(s): _____

4) Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? ☐ No ☐ Yes

5) Estimate the hours the patient needs care on an intermittent basis, if any:

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

6) Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ☐ No ☐ Yes

7) Does the patient need care during these flare-ups? ☐ No ☐ Yes

8) Explain the care needed by the patient, based on your above responses and why such care is medically necessary:

Employee's name: Leave ID:

ADDITIONAL INFORMATION NOT PROVIDED ABOVE RELATIVE TO THE LEAVE REQUEST:

Signature of Employee **Date**

Signature of Health Care Provider **Date**

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 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.

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.