TAXATION & REVENUE NEW MEXICO

CERTIFICATION OF HEALTH CARE PROVIDER FAMILY MEMBER'S SERIOUS HEALTH CONDITION (FMLA) [Fillable version (fill out on computer)]

Section One

INSTRUCTIONS to the EMPLOYEE: Please complete Section I before giving this form to your family member or their medical provider. The FMLA allows us 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. The completion of the paperwork is 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 your FMLA request not being approved. [29 C.F.R. § 825.313.] You have 15 calendar days to return this form. [29 C.F.R. § 825.305.]

Your name: _____
First Middle Last Employee ID (SHARE ID)

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

Relationship of family member to you: _____

If family member is your son or daughter, give their date of birth: _____

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

_____

Employee Signature: Date:

This Form MUST be signed and dated by hand, NOT digitally.

Section Two

For Completion by 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 an answer regarding the frequency or duration of a condition and/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 FMLA coverage. Limit your responses to the condition of the patient for whom the employee needs to care for. Page four (4) provides space to add more information should you need it. Please be sure to sign and date the form on the last page.

Provider's name (please print): _____ Type of practice/medical specialty: _____

Provider's business address: _____

Telephone: _____ Fax: _____

Part A: Medical Facts

1. Approximate date condition commenced: Date: _____

Probable duration of condition: _____

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? No ☐ Yes ☐
If **YES**, date(s) of admission: _____

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

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

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? No ☐ Yes ☐

If **YES**, what was the nature of the evaluation or treatment(s)? _____

And the expected duration of treatment(s)? _____

2. Is the medical condition pregnancy? No ☐ Yes ☐
If **YES**, expected delivery date: _____

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

Part B: Amount of Care Needed—Continuous FMLA

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:

4. Will the patient be incapacitated for a single continuous period of time due to their medical condition, including any time for treatment and recovery? No ☐ Yes ☐

If **YES**, estimate the beginning and ending dates for the period of incapacity: _____

Explain the care needed by the patient while incapacitated and why the care is medically necessary:

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

Is it medically necessary for the employee to be absent from work during the flare-ups? No ☐ Yes ☐

If **YES**, explain the care provided by the employee to the patient during flare-ups:

Based upon the patient's medical history and your knowledge of the medical condition, ***estimate*** the ***approximate*** 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):

Frequency: _____ time per week or _____ per month

Duration: _____ hour(s) or _____ day(s) per episode

Part C: Amount of Care Needed—Intermittent FMLA

6. Will the patient require care on an intermittent or reduced-schedule basis, including any time for recovery?
No ☐ Yes ☐
If **YES**, estimate the hours the patient needs care on an intermittent basis:

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

Explain the care needed by the patient during treatments, and why such care is medically necessary:

7. Will the patient require follow-up treatments, including time for recovery because of the patient's medical condition? No ☐ Yes ☐

If **YES**, estimate treatment schedule, if any, including:

Date of Appointment	Time Required	Recovery Period

Explain the care needed by the patient during treatments, and why such care is medically necessary:

Additional Information: Identify question number with your additional answer.

Print name of Health Care Provider: _____

Signature of Health Care Provider: _____ **Date:** _____

This Form MUST be signed and dated by hand, NOT digitally.