UNIVERSITY SYSTEM OF MARYLAND

Form 3B – Certification of Health Care Provider

Adapted from U.S. Department of Labor Wage & Hour Division – FORM WH-380-F (Family Member's Serious Health Condition)

Confidential Medical Record – Maintain Separately from Personnel File

Attention Health Care Provider: Return completed form to the employee.

This certification is used to evaluate whether the employee's family member's condition qualifies under the federal Family and Medical Leave Act (FMLA) and/or Maryland Paid Family and Medical Leave (PFML). Approval and designation of leave are determined separately by the employer. Information about the FMLA may be found on the WHD website at dol.gov/agencies/whd/fmla.

Section I – Employer

Either the employee or the employer may complete this section.

The FMLA and PFML allow an employer to require an employee seeking leave to care for a family member with a serious health condition to submit a timely, complete, and sufficient medical certification issued by the family member's health care provider.

The employer must generally allow at least fifteen (15) calendar days for the employee to return this certification unless it is not practicable despite the employee's diligent, good faith efforts.

Employers must maintain medical certifications as confidential medical records in files separate from personnel records in accordance with applicable law.

Employee Name: _____ Employee Job Title: _____

Employer Name: _____
(Part of the University System of Maryland)

Employee's Regular Work Schedule:

_____

Date Certification Requested:

_____

Certification Due Date:

_____
(at least 15 calendar days)

Family Member's Name: _____

Relationship to Employee *(as represented by employee)*: _____

Clarification of Family Member Definition

For FMLA, "family member" includes a spouse, parent, or child as defined by federal law. For Maryland PFML, "family member" may include additional relationships as defined by state law. Eligibility determinations are made by the employer.

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 and the Maryland PFML allow an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA/PFML 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 FMLA/PFML protections. 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.

Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA/PFML leave request.

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	○ Domestic Partner	○ Other relationship (specify): _____
○ Parent	○ Grandparent	
○ Child, under age 18	○ Grandchild	
○ Child, *age 18 or older and incapable of self-care because of mental or physical disability*	○ Sibling	
	○ *In loco parentis* 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.

3. Briefly describe the care you will provide for 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:
   _____
   _____

5. If a reduced work schedule is necessary to provide the care described, give your best estimate of the reduced schedule you are able to work. From the date of _____ to the date of _____, I am able to work _____ (hours per day) _____ (days per week).

Employee Signature _____ **Date** _____

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 Name (Print): _____

Business Address: _____

Type of Practice / Medical Specialty: _____

Telephone: _____ Fax: _____ Email (optional): _____

University System of Maryland

PART A: MEDICAL INFORMATION

Limit your response to the medical condition for which the employee is seeking FMLA/PFML 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: _____
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).
   _____
   _____
   _____
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 _____ (nm/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. Expected delivery date: _____

☐ 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.

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)*

_____
_____
_____
_____
_____
_____

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 if the benefits and protections of the FMLA apply.

1. 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): _____

2. 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)* _____

   Provide your **best estimate** of the beginning date _____ and end date _____ or the treatment(s).

   Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery *(e.g. 3 days/week)* _____

3. 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. From _____ to _____ the employee is able to work *(e.g., 5 hours/day, up to 25 hours a week)*: _____

4. 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 _____ and end date _____ for the period of incapacity.

5. Due to the condition, it (◯was / ◯is / ◯will be) medically necessary for the employee to be absent from work to provide care for the patient on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

   Over the next 6 months, episodes of incapacity are estimated to occur _____ times per (◯day / ◯week / ◯month) and are likely to last approximately _____ (◯hours/ ◯days) per episode

Part C: Health Care Provider Certification

I certify that the information provided is true and complete to the best of my knowledge.

Printed Name: _____

Health Care Provider Signature: _____ Date: _____

License Number (if applicable): _____ State of Licensure: _____

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DEFINITIONS OF A SERIOUS HEALTH CONDITION

(Adapted from 29 C.F.R. §§ 825.113–825.115)

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: • 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, • 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 the treatment.