

**Certification of Health Care Provider for Family Member's  
Serious Health Condition  
Family and Medical Leave Act (WH-380-F)**

Return form to: Dartmouth College Benefits Office, 7 Lebanon Street, Suite 203, Hanover, NH 03755 Fax: 603-646-1108

**SECTION I: For Completion by the EMPLOYER**

**INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies. Employer name and contact:

**SECTION II: For Completion by the EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II 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 to your employer. 29 C.F.R. § 825.305.

Your name: \_\_\_\_\_  
First Middle Last

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, date of birth: \_\_\_\_\_



Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? \_\_\_No \_\_\_Yes

If so, dates of admission: \_\_\_\_\_

Date(s) you treated the patient for condition:  
\_\_\_\_\_

Was medication, other than over-the-counter medication, prescribed? \_\_\_No \_\_\_Yes

Will the patient need to have treatment visits at least twice per year due to the condition? \_\_\_No \_\_\_Yes

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:  
\_\_\_\_\_  
\_\_\_\_\_

2. Is the medical condition pregnancy? \_\_\_No \_\_\_Yes If so, 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:** 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, including any time for treatment and recovery? \_\_\_No \_\_\_Yes

Estimate the beginning and ending dates for the period of incapacity:  
\_\_\_\_\_

During this time, will the patient need care? \_\_\_No \_\_\_Yes

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

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5. Will the patient require follow-up treatments, including any time for recovery?  
 No  Yes

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

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

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

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

\_\_\_\_\_ hour(s) per day; \_\_\_\_\_ days per week  
from \_\_\_\_\_ through \_\_\_\_\_

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

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

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):

Frequency: \_\_\_\_\_ times per \_\_\_\_\_ week(s) \_\_\_\_\_ month(s)

Duration: \_\_\_\_\_ hours or \_\_\_\_\_ day(s) per episode

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

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

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ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR  
ADDITIONAL ANSWER. \_\_\_\_\_

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\_\_\_\_\_  
**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. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. 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. 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 Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**