MetLife

Certification of health care provider for family member health condition Family and Medical Leave Act (FMLA)

Metropolitan Life Insurance Company

Things to know before you begin

- Please complete Sections 1 and 2 before giving this form to the 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 due to your family member's serious health condition. Your response is required to obtain or retain the benefits of FMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request.
- Remember to include your First name, Last name and Claim number in the spaces provided on all pages of this form.

Reminder: Forms marked as lifetime, unknown, as needed, indeterminate or the like, may be returned as incomplete.

SECTION 1: Employee/Caregiver Information

Employee - First name	Middle initial	Last name	Claim number

Employer's name

Please provide a short description on the type of care needed:

By signing below, I certify that the intent of the information in this document is to support my need to be absent from work in order to provide care for my family member.

Sign Here	Signature of Employee	Date signed *(mm/dd/yyyy)*

First name	Middle initial	Last name	Claim number

SECTION 2: Patient/Family Member Information

Patient - First name	Middle name	Last name

Date of birth *(mm/dd/yyyy)*

Gender
☐ Male ☐ Female

Relationship to employee: Please check ONLY one.

Child
- ☐ Child *(under age 18)*
- ☐ Child *(over age 18)**
  - ☐ *With Disability**

Parent
- ☐ Parent
- ☐ Parent-in-law

Partner
- ☐ Spouse**
- ☐ Domestic partner
- ☐ Civil union partner

Other
- ☐ Describe relationship in the box provided below.

Description of **Other:**

* With Disability means Disabled Adult Child/ADA Qualified: Individual age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA leave is to commence that substantially limits 3 or more ADLs or IADLs.
** *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.

SECTION 3: Health Care Provider Instructions

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 a response as to the frequency or length of a condition or treatment. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Limit your responses to the condition for which the employee is seeking leave. Be as specific as you can; terms such as *lifetime, unknown, as needed, or indeterminate* may not be sufficient to determine FMLA coverage. Without sufficient medical facts, this form may be returned as incomplete. Please be sure to sign the form on the last page.

Which of the following best describes your patient's medical condition? ☐ Pregnancy ☐ Injury ☐ Illness

If pregnancy, please provide date (*select one*): ☐ Estimated delivery date

☐ Actual delivery date _____

What is the approximate date the condition commenced? _____

What is the expected duration the condition will last? _____

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

Was medication prescribed that may not be obtained over the counter? ☐ Yes ☐ No

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? If yes, please provide admission and discharge dates below. ☐ Yes ☐ No

First name	Middle initial	Last name	Claim number

Date admitted (*mm/dd/yyyy*)	Date discharged (*mm/dd/yyyy*)

Dates you treated the patient for this condition:

First visit *(mm/dd/yyyy)*	Last visit *(mm/dd/yyyy)*	Next visit *(mm/dd/yyyy)*

In the space provided below, please describe relevant medical facts, if any, related to the condition for which the employee seeks leave from work (i.e., *pregnancy complications, or any regimen of continuing treatment such as the use of specialized equipment).*

In the space provided below, please describe the care needed for the patient and why such care is medically necessary. If care is for an adult child, List ADLs or IADLs your patient requires support to perform (i.e., *cooking, toileting, travel to appointments*).

Are there any other treating physicians or consultants involved in your patient's care? ☐ Yes ☐ No

SECTION 4: Amount of Leave Needed

Continuous absence details: Will the employee listed above need to be absent from work to care for your patient's (*the employee's family member*) serious health condition? If so, please select the checkbox below and provide accurate or estimated dates for this period of absence.

☐ Single continuous absence period

Start date *(mm/dd/yyyy)*	End date *(mm/dd/yyyy)*

Intermittent absence details: Will the employee listed above require an intermittent absence and/or reduced work schedule to care for your patient's *(the employee's family member)* serious health condition? If so, please check the box below and provide approximately how long your patient will need the intermittent support outlined below.

☐ Intermittent absence/Reduced work schedule

Start date *(mm/dd/yyyy)*	End date *(mm/dd/yyyy)*

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 will need the support outlined below.

Example:

FREQUENCY of episode 02 times per: ☐ week, or ☒ month, or ☐ year

LENGTH of episode: ___ minute(s) 01 hour(s) ___ full day(s)

FREQUENCY of episode ___ **times per**: ☐ week, or ☐ month, or ☐ year

LENGTH of episode: ___ minute(s) ___ hour(s) ___ full day(s)

First name	Middle initial	Last name	Claim number

In the space provided below, please list any past or future absence dates due to treatments, recovery, flare-ups, and travel time due to this medical condition. Provide any additional relevant information specific to the need for family members to take time away from work to care for your patient.

SECTION 5: Health Care Provider Information

Physician - First name	Middle name	Last name

Physician area of specialty *(i.e., General Practitioner, Oncologist, Obstetrician)*

Office phone number	Office fax number

Office email address

Office address	Suite

City	State	ZIP code

Please Read:

GINA Disclaimer: 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, 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.

Fraud Notice: Any person who knowingly and with intent to injure, defraud, or deceive any person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information is/may be guilty of a crime and may be prosecuted and punished. Penalties may include fines, civil damages and criminal penalties, including confinement in prison.

By signing below, I attest that I am the treating health care provider to the listed patient. The clinical information I am providing is in regards to the dates of absences listed above. I certify that my patient's family member (*employee*) must be absent from work or have a modified work schedule due to this condition.

Sign Here	Signature of health care provider	Date *(mm/dd/yyyy)*

SECTION 6: How to Submit this Form

Mail:
MetLife Disability
PO Box 14590
Lexington KY 40512-4590

Fax:
1-800-230-9531