

Family Medical Leave Act (FMLA) Certification for Employee's Serious Health Condition¹

Return completed form to: Aetna Life Insurance Company

PO Box 14560

Lexington, KY 40512-4560 Fax: 866-667-1987

SECTION I: For Completion by the EMPLOYEE:

INSTRUCTIONS to the EMPLOYEE:

Please complete Section I before giving this form to your medical provider. The FMLA permits an employer² to require that you submit a timely, complete, and sufficient medical certification to support your request for FMLA leave due to your own serious health condition. If requested by your employer, completion of this certification is needed for you to get or keep 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 delay or denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Last Name	First Name	Middle Initial
Employer Name	Job Title	
lob Description & Essential Job Functions (Please desc	cribe with details):	
How many hours are you scheduled to work each wee	ek?	
Please circle your scheduled work days: SAT SU	N MON TUE WED THUR FR	RI
If your schedule varies each week, please che	ck here:	
On the days that you work, are you scheduled to worl	k the same number of hours each	day?
What time are you scheduled to begin and end your v	vork day?	
Are you paid overtime if you work more than 40 hours	s in a week? 🗌 No 🔲 Yes	
What is the reason for your FMLA request? Employee's serious health condition (other the	nan pregnancy):	
☐ Pregnancy/Childbirth - Estimated Date of De		
	- y	
Employee's Signature:		Date:

¹ This Certification may also be used for certification of state leaves and employer's company leaves.

² Reference to your employer extends to Aetna in its capacity as your employer's third party administrator.

SECTION II: For Completion by the HEALTH CARE PROVIDER:

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient, referred to here as "the employee," has requested leave under the FMLA. Please answer all applicable sections fully and completely. 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 employee. Be as specific as you can; terms such as "as medically necessary," "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. *Please limit your responses to the condition for which the employee is seeking leave*, and 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 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.

Employee's Name:						
Pro	Provider's name and business address:					
Туј	Type of practice / Medical specialty:					
Tel	lephone: () Fax: ()					
P/	ART A: MEDICAL FACTS					
Please provide the following information regarding the employee's medical condition. Approximate date condition commenced:						
				Probable duration of condition:		
	Mark below as applicable: Was the employee admitted for an overnight stay in a hospital, hospice, or residential medical care facility? No Yes If yes, dates of admission and duration of stay:					
	Date(s) you treated the employee for the condition requiring leave: Most recent date of treatment by you or another provider:					
	Will the employee need to have treatment visits at least twice per year due to the condition? No Yes					
	Will the employee need to be treated again in the future for this condition? Please provide dates of any such treatments that have been scheduled, or, if no future treatments have been scheduled, please indicate when and how often they will be needed.					
	Has medication, other than over-the-counter medication, been prescribed? No Yes Has the employee been referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? No Yes					

2.	Is t	s the medical condition pregnancy? No Yes					
	If s	so, expected delivery date:					
3.	pro	Use the information provided by the employer, if available, to answer these questions. If the employer has not provided a list of the employee's essential functions or a job description, please answer these questions based upon the employee's own description of his or her job functions.					
	ls t	the employee unable to pe	rform any of his or her jo	b functions due to the condition?			
	If s	so, identify the job function	ns the employee is unable	to perform:			
4.				tment being provided to the employee consist of manual emonstrated by an X-ray? No Yes			
5.	me			the condition for which the employee seeks leave (such regimen of continuing treatment such as the use of			
P <i>P</i>	\RT	B: AMOUNT AND NA	TURE OF LEAVE NE	EDED			
6.	Wh	en will the employee be ir	capacitated from work?	(Please select and complete one of the options below.)			
		. ,	•	with an expected return to work on			
			tion 7. If the employee will no	ermittently due to his or her condition before or after this time eed to work a consistently reduced number of hours due to his or ete question 8.)			
		Beginning on	and lasting for the	following amount of time:			
		(If the employee will also nee period, please complete quest	o need to be absent from work intermittently due to his or her condition before or after this time question 7. If the employee will need to work a consistently reduced number of hours due to his or ifter this time period, please complete question 8.)				
		The employee is or will be incapacitated intermittently, not for a specific timeframe. (Please complete ques 7.)					
		The employee can continue working, but will need to work a consistently reduced number of hours per day or per week. (Please complete question 8.)					

7.		the employee will need to be absent intermittently, please provide the following information. The employee's rk schedule may be available on page 1 for reference.			
	•	How long will the employee be affected by this condition?			
	•	Will the condition cause episodic or unpredictable flare-ups periodically preventing the employee from performing his or her job functions? No Yes			
		Is it medically necessary for the employee to be absent from work during these flare-ups? No Yes If yes, please explain:			
		If you answered yes to both prior questions, please estimate the frequency of flare-ups and the duration of related incapacity that the employee may experience over the next 6 months, based on the employee's medical history and your knowledge of the medical condition (e.g., 1 episode every 3 months lasting 2 days):			
		FREQUENCY: time(s) every: week(s) month(s)			
		(Example: time(s) every: week(s) month(s) to indicate "once every 3 months")			
		DURATION: hour(s) day(s) per episode			
		(Example: hour(s) 2 day(s) per episode to indicate "2 days per episode")			
	•	Will intermittent absences be required due to follow-up or other medical appointments? ☐ No ☐ Yes			
	If yes, please estimate the frequency of these appointments and the duration of absence required for appointments, including the time it may take for the employee to travel to the appointments (e.g., 1 to every 3 months lasting 2 hours):				
		FREQUENCY: time(s) every: week(s) month(s)			
		(Example: time(s) every:			
		DURATION: hour(s) day(s) per appointment			
		(Example: 2 hour(s) day(s) per appointment to indicate "2 hours per appointment")			
8.		the employee's condition will require him or her to work a reduced work schedule, please provide the owing information. The employee's regular work schedule may be available on page 1 for reference.			
	ls i	it medically necessary for the employee to work a reduced number of hours? No Yes			
	If yes, please explain:				
	•	How long will the employee be affected by this condition? How many hours will the employee be able to work per day? Mon Tue Wed Thurs Fri Sat Sun Or: how many hours will the employee be able to work per week?			

 What medical restrictions will the employee have, if any 	y, while working these reduced hours?			
 When will the employee be able to resume his or her re 	egular work schedule?			
ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.				
Signature of Health Care Provider	 Date			