CIGNA Leave Solutions®

Certification of Health Care Provider for Pregnancy Disability Leave/Employee's Serious Health Condition (Family and Medical Leave Act)

Complies with DOL Form WH-380-E Revised January 2009

Date Prepared: Must Be Returned By:

Employee Name:

Employer Name:

Leave ID:

Reason for requesting leave:

Leave date(s)/Period(s) requested:

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 employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own 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. 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).

In addition, you may qualify for leave under California's Pregnancy Disability Leave statute or the California Family Rights Act. Information provided on this certification will be evaluated for eligibility under any applicable state family medical leave, as well as the federal FMLA as permitted by law. Please have your Health Care Provider complete this form as indicated below.

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 employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information, unless failing to provide the information will result in an incomplete or insufficient certification..'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.

SECTION III OF THIS FORM SHOULD NOT BE COMPLETED IF YOU ARE SEEKING LEAVE RELATED TO A DISABILITY FROM PREGNANCY, CHILDBIRTH, OR RELATED CONDITIONS.

Return completed certification form to:
CIGNA Leave Solutions®
P.O. Box 709015
Dallas, TX 75370-9015
Fax: 1-866-931-5095

Employee Job Title: _____

Regular Work Schedule: _____

_____ _____

Employee Signature **Date**

SECTION II: For Completion by the HEALTH CARE PROVIDER for LEAVE RELATED TO DISABILITY FROM PREGNANCY, CHILDBIRTH, OR RELATED CONDITIONS

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested a leave of absence relating to a disability from pregnancy, childbirth, or related conditions. Please **ONLY COMPLETE SECTION II** of this form.

YOU SHOULD NOT COMPLETE SECTION III OF THIS FORM IF YOUR PATENT HAS REQUESTED A LEAVE OF ABSENCE RELATING TO A DISABILITY FROM PREGNANCY, CHILDBIRTH, OR RELATED CONDITIONS.

Employee's Name: _____

Date employee disabled due to pregnancy, childbirth, or related medical condition: _____

I anticipate that the above named employee will be disabled for _____ _____ (amount of time continuously or intermittently) or expected to return to work on date: _____

I hereby certify that the employee named above is disabled because of pregnancy, childbirth or related medical conditions as of the date stated above and that the employee is unable to work at all or is unable to perform any one or more of the essential functions of her position without undue risk to herself or to other persons, or to the successful completion of her pregnancy.

_____ _____

Signature of Physician or Practitioner Date

Physician or Practitioner Information:

_____

Physician's or Practitioner's Name

_____

Address

_____ ___ _____-____

City State Zip

(___) ___ - ____

Telephone

SECTION III: For Completion by the HEALTH CARE PROVIDER for SERIOUS HEALTH CONDITION OTHER THAN PREGNANCY DISABILITY

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA and/or the California Family Rights Act (CFRA). Answer, fully and completely, all applicable parts. 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 FMLA/CFRA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

SECTION III OF THIS FORM SHOULD NOT BE COMPLETED IF YOUR PATIENT HAS REQUESTED A LEAVE OF ABSENCE RELATING TO A DISABILITY FROM PREGNANCY, CHILDBIRTH, OR RELATED CONDITIONS.

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____) _____ Fax :(_____)_____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Mark below as applicable:
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: _____

Will the patient need treatment visits at least twice per year due to the condition? ___No ___Yes

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 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. Answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition: __No __Yes

If so, identify the job functions the employee is unable to perform:

_____

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms or any regimen of continuing treatment such as the use of specialized equipment. **Do not include diagnosis**.

_____

_____

_____

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? ___No ___Yes

If so, estimate the beginning and ending dates for the period of incapacity

_____

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? ___No ___Yes

If so, are the treatments or the reduced number of hours of work medically necessary? ___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:

_____

Estimate the part-time or reduced work schedule the employee needs, if any:

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

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ____No ____Yes

Is it medically necessary for the employee to be absent from work during the flare-ups?
____ No ____ Yes. If so, explain:

_____

_____

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) or _____ month(s)

Duration: _____ hours or ___ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider **Date**

PAPERWORK REDUCTION ACT NOTICE AND 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. The U.S. 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 AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**