

U.S. Department of Labor Wage and Hour Division	Certification of Health Care Provider for Family Member's Serious Health Condition	WH-380-F Revised June 2020 OMB 1235-0003
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INSTRUCTIONS TO THE EMPLOYEE: Complete Section I, then have your health care provider complete Section II. Return this form within 15 calendar days of the employer's request. Do not provide a diagnosis or attach medical records.

SECTION I: EMPLOYEE AND FAMILY MEMBER INFORMATION

Employee

Name: _____ Date: _____

Employer / Organization: _____

Family Member's Name: _____

Relationship to employee:

- ☐ Spouse
- ☐ Child (under 18 or incapable of self-care)
- ☐ Parent
- ☐ Next of kin (serious servicemember injury)
- ☐ Other qualifying relationship: _____

Anticipated Leave Start Date: _____ Anticipated Duration: _____

SECTION II: HEALTH CARE PROVIDER INFORMATION AND CERTIFICATION

INSTRUCTIONS TO HEALTH CARE PROVIDER: Answer each question fully. Provide functional limitations and prognosis only. Do not include a diagnosis. See 29 CFR § 825.306.

Provider Name / Specialty: _____

Address / Phone: _____

SECTION III: MEDICAL FACTS (Family Member's Condition)

- Approximate date family member's condition commenced: _____
- Probable duration of condition: _____
- Was the family member admitted for an overnight stay in a hospital, hospice, or residential facility?
 - ☐ Yes ☐ No
- Does the family member require assistance with basic medical, hygiene, nutritional needs, safety, or transportation?
 - ☐ Yes ☐ No
- Will the employee need to provide intermittent care? If yes, estimated frequency and duration:

SECTION IV: HEALTH CARE PROVIDER SIGNATURE

Signature: _____ Date: _____