

U.S. Department of Labor Wage and Hour Division	Certification of Health Care Provider for Employee's Serious Health Condition	WH-380-E Revised June 2020 OMB 1235-0003
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INSTRUCTIONS TO THE EMPLOYEE: Please complete Section I and give this form to your health care provider. Your health care provider must return the completed form to your employer within 15 calendar days.

IMPORTANT: Do not provide your employer with medical records or a diagnosis. This form asks only for functional limitations and prognosis information necessary to administer your FMLA leave.

SECTION I: EMPLOYEE INFORMATION (to be completed by the employee)

Employee Name: _____ Date: _____

Employer / Organization: _____

Employee ID: _____ Job Title: _____

Reason for leave request (reason category only — do not include diagnosis):

Anticipated Leave Start Date: _____ Anticipated Duration: _____

SECTION II: HEALTH CARE PROVIDER INFORMATION (to be completed by health care provider)

INSTRUCTIONS TO THE HEALTH CARE PROVIDER: Your patient has requested leave under FMLA. Answer fully and completely. Do not provide diagnosis or confidential medical information beyond what is necessary to determine the need for leave. See 29 CFR § 825.306.

Health Care Provider Name: _____

Type of Practice / Specialty: _____

Address: _____ Phone: _____

License / NPI Number: _____

SECTION III: MEDICAL FACTS

- Approximate date condition commenced: _____
- Probable duration of condition: _____
- Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
☐ Yes ☐ No
- Was medication prescribed that may cause incapacity (e.g., sedation, drowsiness)?
☐ Yes ☐ No If yes, approximate duration: _____
- Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule?
☐ Yes ☐ No If yes, estimated frequency and duration of appointments:

SECTION IV: ABILITY TO PERFORM JOB FUNCTIONS

Is the employee unable to perform any of their job functions due to the condition?

☐ Yes ☐ No ☐ Intermittently

If intermittent, estimated frequency of episodes and duration per episode:

SECTION V: HEALTH CARE PROVIDER SIGNATURE

Signature: _____

Date: _____

Paperwork Reduction Act Notice: Public reporting burden for this collection is estimated to average 20 minutes per response. Persons are not required to respond to this collection unless it displays a currently valid OMB control number. OMB 1235-0003.