



**REQUEST FOR FMLA CERTIFICATION**  
MIDLANDS ORTHOPAEDICS, PA (MOPA)  
1910 Blanding Street, Columbia, SC 29201  
(Ph) 803.256.4107x6139 \* (Fax) 803.933.6317



Provide the following information to request a Certification of Health Care Provider statement for the Family and Medical Leave Act (FMLA). Please submit this completed form with the blank form provided by your employer via mail, fax or hand delivery to a front desk staff member.

Employee Name:

Patient's Name (if different than employee):

Patient's Date of Birth:

Address:

City:

State:

Zip:

Treating Physician:

I am seeking certification of the care provided for the following illness or injury. Include the location of the illness injury (for example, hip, knee, back):

Please indicate if the patient has received any of the following procedures:

Inpatient Surgery  Outpatient Surgery  MRI  Injection

Is the patient attending Physical Therapy?

**List the name, address, and/or fax number where your forms should be sent:**

Name:

Address:

City/State/Zip:

Fax:

Are you willing to receive your completed form via a secure electronic portal?

If so, please include an email address so we can let you know when it is ready: \_\_\_\_\_

*I authorize Midlands Orthopaedics, PA to release all information requested by my employer for the processing of my FMLA Certification.*

Signature: \_\_\_\_\_

Date: \_\_\_\_\_