CERTIFICATION OF HEALTH CARE PROVIDER – FAMILY AND MEDICAL LEAVE ACT

PART A: For Completion by the EMPLOYEE:

Please complete all applicable sections of Part A before giving this form to your family member or your/their health care provider. You have at least 15 calendar days to return this form. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. Please sign the form in Section III.

1. **Your Name:** _____
First **Middle** **Last**

Job title: _____ **Life Number: _____**

Department Name: _____ **Your Telephone Number: _____**

Supervisor Name: _____ **Telephone Number: _____**

2. You have requested to take a leave due to (check applicable category):

☐ The birth of a child, or placement of a child with you for adoption or foster care; *(proceed to Page 2 – Part B):*

☐ Your own serious health condition (*proceed to Page 2 - Part B);*

☐ A serious health condition affecting your ☐ spouse, ☐ child, ☐ parent for which you are needed to provide Care *(proceed to Section I)*

Section I: Family Member Serious Health Condition Information

3. Name of Family Member for whom you will provide care:

_____
First **Middle** **Last**

4. Relationship of family member to you: _____

If family member is son or daughter, date of birth: _____

5. Describe care you would provide to your family member and an estimate of the period during which care will be provided:

_____

_____

_____

_____

_____

_____ _____
Employee Signature Date

PART B: For Completion by the HEALTH CARE PROVIDER:

The employee and/or your patient listed on the previous page has requested leave under the FMLA. Fully and completely answer all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Be as specific as you can: terms such as "lifetime", "unknown" or "indeterminate" may not be sufficient to determine FMLA coverage. Please sign the form on Page 4.

6. Page 5 describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category:

☐ **1.** ☐ **2.** ☐ **3.** ☐ . **4.** ☐ **5.** ☐ **6.** ☐ **None of the above**

7. Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

_____

_____

_____

_____

8. Approximate date condition commenced: _____

Probable duration of condition: _____

9. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
No ☐ Yes ☐

If so, dates of admission: _____

10. Date(s) you treated the employee/patient for condition: _____

11. Will the employee/patient need to have treatment visits at least twice per year due to the condition? No ☐ Yes ☐

12. Was medication, other than over-the-counter medication, prescribed? No ☐ Yes ☐

13. 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:

_____

_____

_____

14. Is the medical condition pregnancy? ☐ No ☐ Yes

If so, expected delivery date: _____

15. Describe other relevant medical facts, if any, related to the condition from which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

_____

_____

_____

16. Will the employee/patient be incapacitated for a single continuous period of time, including any time for treatment and recovery?

No ☐ Yes ☐

Estimate the beginning and ending dates for the period of incapacity: _____

During this time, will the employee/patient need care? No ☐ Yes ☐

Explain the care needed by the employee/patient and why such care is medically necessary:

_____

_____

_____

17. Will the employee/patient need to attend follow–up treatments appointments or work on an intermittent, part-time or on a reduced schedule because of their medical condition? No ☐ Yes ☐

If so, are the treatments or the reduced number of hours of work/such care 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:

_____

_____

_____

18. Will the condition cause episodic flare-ups periodically preventing the employee/patient from performing his/her job functions or from participating in normal daily activities?
No ☐ Yes ☐

Is it medically necessary for the employee/patient to be absent from work/need care during the flare-ups?
No ☐ Yes ☐

19. If leave is required to care for a family member with a serious health condition, does the patient require assistance for basic medical, personal needs, safety or for transportation? No ☐ Yes ☐

If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? No ☐ Yes ☐

20. Is the employee/patient unable to perform any of his/her job functions due to the condition? No ☐ Yes ☐

If so, identify the essential functions the employee/patient is unable to perform (job description is attached):

_____

_____

_____

_____ _____
PRINT Name of Health Care Provider **SIGNATURE of Health Care Provider**

_____
Date

_____ _____
Name of Practice **Type of Practice/Medical Specialty**

_____ _____
Address **Telephone Number**

_____ _____
City, State, Zip Code **Fax Number**

A "Serious Health Condition" means an illness, injury impairment, or physical or mental condition that involves one of the following:

1. Hospital Care

Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity[1] or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

(a) A period of incapacity[1] of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity[1] relating to the same condition that also involves:

(1) **Treatment [2]two or three times** by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or a provider of health care services (e.g., physical therapist) under orders of , or on referral by, a health care provider, or

(2) **Treatment** by a health care provider on **at least one occasion** which results in a **regimen of continuing treatment[3]** under the supervision of the health care provider

The two visits must occur within 30 days of the beginning of the period of incapacity and the first visit must take place within seven (7) days of the first day of incapacity.

3. Pregnancy

Any period of incapacity due to **pregnancy,** or for **prenatal care**.

4. Chronic Conditions Requiring Treatments

A **chronic condition** which:

(1) Requires **periodic visits** for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider. **Periodic visits** are defined as two (2) visits to a health care provider per year.

(2) Continues over an **extended period of time** (including recurring episodes of a single underlying condition); and

(3) May cause episodic rather than a continuing period of incapacity[1] (e.g., asthma, diabetes, epilepsy, etc.)

5. Permanent/Long-term Conditions Requiring Supervision

A period of incapacity[1] which is **permanent or long-term** due to a condition for which treatment may not be effective. The employee or family member must be **under the continuing supervision of, but need not be receiving active treatment by, a health care provider**. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. Multiples Treatments (Non-Chronic Conditions)

Any period of absence to receive multiples treatments (including any period of recovery there from) by a health care provider or by a provider of health care services under orders of, or on referral by a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment such has cancer (chemotherapy, radiation, etc.) , severe arthritis (physical therapy), and kidney disease (dialysis).

This optional form may be used by employees to satisfy a mandatory requirement to furnish a medical certification (when requested) from a health care provider, including second or third opinions and recertification.

[1] "Incapacity" for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition , treatment thereof, or recovery there from.

[2] Treatment includes examinations to determine if a serious health condition exists and evaluations of the conditions. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

[3] A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., a antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over –the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE; RETURN THE FORM TO THE EMPLOYEE/PATIENT