Certification of Health Care Provider 1 of 3

(Family and Medical Leave Act of 1993)

1. Name of employee

_____

First Name Middle Initial Last Name

2. _____

Patient's Name *(if other than employee)*

3. The attached sheet describes what is meant by a **"serious health condition"** under the Family and Medical Leave Act. Does the patient's condition**1** qualify under any of the categories described? If so, please check the applicable category.

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

4. 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:

_____

_____

_____

5a. State the approximate **date** the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present **incapacity**[2] if different):

_____

_____

_____

5b. Will it be necessary for the employee to take work only **intermittently** or **to work on a less than full schedule** as a result of the condition (including for treatment described in item 6 below)? If yes, give the probable duration:

_____

_____

_____

5c. If the condition is a **chronic condition** (condition #4) or **pregnancy**, state whether the patient is presently i**ncapacitated** [2] and the likely duration and frequency of episodes of **incapacity** [2]:

_____

6a. If **additional treatments** will be required for the condition, provide an estimate of the probable number of such treatments:

_____

_____

If the patient will be absent from work or other daily activities because of treatment on an **intermittent** or **part-time basis,** also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

6b. If any of these treatments will be provided by **another provider of health services** (e.g., physical therapist), please state the nature of the treatments:

_____

_____

_____

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., and overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity[3] or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

a). A period of **incapacity**[2] of more than three consecutive calendar days (including any subsequent treatment or period of **incapacity**[2] relating to the same condition), that also involves:

(1) **Treatment**[4] **two or more times** by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by 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**[4] under the supervision of the health care provider.

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;

(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**[2] (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-term Conditions Requiring Supervision

A period of **incapacity**[2]**, 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. Multiple Treatments (Non-Chronic Conditions)

Any period of absence to receive multiple treatments (including any period of recovery therefrom) by 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**[2] **of more than three consecutive calendar days in the absence of medical intervention or treatment,** such as a cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

6a. If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

_____

7a. If medical leave is required for the employee's **absence from work** because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind?

_____

7b. If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job (the employee or the employer should supply you with information about the essential job functions)?

_____

If yes, please list the essential functions the employee is unable to perform:

_____

7c. If neither **a** nor **b** applies, is it necessary for the employee to be absent from work for treatment?

_____

8a. If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic or personal needs or safety, or for transportation?

8b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery?

8c. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need:

_____

Signature of Health Care Provider | Type of Practice

_____

Address | Telephone Number

To be completed by the employee needing family leave to care for a family member:
State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

_____

Employee Signature | Employee Number | Date

1. Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.
2. 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 therefore, or recovery there from.
3. Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.
4. A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an 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.