



CERTIFICATION OF HEALTH CARE PROVIDER

Employee Name: _____

Individual with serious health condition (circle one): Employee Family Member

If family member, family member's name: _____ Relation: _____

INSTRUCTIONS TO HEALTH CARE PROVIDER: *This certification will be used to determine employee eligibility for FMLA leave due to either the employee's own or a family member's "serious health condition." The attached Terms and Definitions describe what is meant by a serious health condition under the Family and Medical Leave Act. THE INFORMATION SOUGHT ON THIS FORM RELATES ONLY TO THE CONDITION FOR WHICH THE EMPLOYEE IS REQUESTING FMLA LEAVE AND SHOULD BE RETURNED DIRECTLY TO THE EMPLOYEE'S HUMAN RESOURCE OFFICE.*

1. Does the patient's condition qualify under any of the following categories? (Please see the attached Terms and Definitions for a definition of each category.) Please check the most applicable category.

- Hospital Care _____ Absence Plus Treatment _____
- Chronic Conditions Requiring Treatment _____ Pregnancy _____
- Multiple Treatments (Non-Chronic Conditions) _____ None of the Above _____
- Permanent/Long-term Conditions Requiring Supervision _____

2. Please make a brief statement as to how the medical facts meet the criteria of the category checked in #1:

3. Please indicate the following:

- a. The approximate date the condition commenced: _____
- b. The probable duration of the condition: _____
- c. If the patient is incapacitated, the estimated duration of *incapacity*: ("Incapacity" means the inability to work or perform other regular daily activities due to a serious health condition, treatment thereof, or recovery therefrom.)

- d. If the patient is not incapacitated, or **following any** period of incapacity, will it be necessary for the patient to work only intermittently or to work a less than a full-time schedule as a result of the condition? (circle one) Yes No
- e. If intermittent leave or a less than full-time schedule is required, please indicate the approximate duration of this need: _____

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- f. If intermittent leave or a less than full-time schedule is required, please indicate the expected frequency of absence (i.e., once per week, once per month, twice per month, etc.): _____
4. If a regimen of continuing treatments by the patient is required, please provide a general description of and the estimated intervals and duration of the regimen (e.g., prescription drugs, physical therapy twice per week for 6 weeks, follow-up examination in 1 month):
- _____
- _____

******Complete Questions 5 - 8 only if leave is requested for the employee to care for a family member with a serious health condition.******

5. Does the patient require assistance for basic medical or personal needs, for safety, or for transportation? (circle one) Yes No
6. If "No", would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? (circle one) Yes No
7. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need: _____
8. If intermittent leave or a less than full-time schedule is required, please indicate the expected frequency of absence (i.e., once per week, once per month, twice per month, etc.): _____

THIS SECTION TO BE COMPLETED ONLY BY THE HEALTH CARE PROVIDER

Signature of Health Care Provider

Date

Address

Type of Practice

Telephone Number: _____

Certification of Health Care Provider --Terms and Definitions

Incapacity – Incapacity for purposes of FMLA is defined to mean inability to work, attend school or perform other regular daily activities due to a serious health condition, treatment thereof, or recovery therefrom.

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

Regimen of Continuing Treatment – 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.

Serious Health Condition – An illness, injury, 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 or subsequent treatment in connection with or consequent to such inpatient care.
2. **Absence Plus Treatment** – A period of incapacity of more than three consecutive days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves either of the following:
 - a. Treatment 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 an referral by, a health care provider; or
 - b. Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of a health care provider.
3. **Pregnancy** – Any period of incapacity due to pregnancy, or for prenatal care.
4. **Chronic Conditions Requiring Treatment** – A chronic condition which:
 - a. 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;
 - b. Continues over an extended period of time (including recurring episodes of a single underlying condition); and
 - c. May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.)
5. **Permanent/Long-term Conditions Requiring Supervision** – A period of incapacity that 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 a health care provider or by a provider of health care services under order 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 as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), or kidney disease (dialysis).