

Certification of Health Care Provider for Family or Medical Leave

*This form contains medical information.
It must be filed separately from employee
personnel records with access limited to
authorized personnel.*

To Be Completed by Employee

Name _____

Payroll Number _____

Department _____

Date ____/____/____

I am requesting family or medical leave from _____
NAME OF EMPLOYER

The physician or healthcare provider is treating _____
NAME OF PATIENT

The Patient is: Myself Spouse Parent Child

I am requesting leave from ____/____/____ to ____/____/____ or an intermittent or reduced schedule on the following dates: _____

(If applicable) I will be providing the following care for a family member with a serious health condition on the following dates:

(If applicable) The essential functions of my job are (or attached job description):

The rest of this form is to be completed by an authorized health care provider to verify the necessity of Family or Medical Leave requested by the above employee. Under the Family and Medical Leave law, an authorized health care provider:

- is any health care provider recognized by the employer or the employer's group health plan.
- is a doctor of medicine or osteopathy authorized to practice medicine or surgery by the state in which he or she practices.
- are podiatrists, dentists, clinical psychologists, optometrists c. chiropractors (limited to manual manipulation of the spine to correct a subluxation found by X-ray to exist) authorized to practice, and performing within the scope of their practice, under state law.
- are nurse practitioners, nurse-midwives, or clinical social workers authorized to practice, and performing within the scope of their practice, as defined under state law, or
- are Christian Science practitioners listed with the First Church of Christ, Scientist in Boston, MA.

The information asked for on this form relates only to the condition for which the employee is taking FMLA leave.

After receiving this completed form, the employer is not permitted to contact the health care provider for additional information. A health care provider representing the employer may contact the health care provider for clarification of information contained on this form.

To be Completed by Authorized Health Care Provider

I. See page 4 for the definition of 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 or None of the above

II. 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: _____

III. State the approximate date the condition commenced and the probable duration of the condition (and the probable duration of the patient's incapacity, if different): _____

Will it be necessary for the employee to work only intermittently or to work on a less-than-full schedule, as a result of the condition (including treatment described in item IV)? Yes No

If yes, give probable duration: _____

If the condition is a chronic condition (Category #4) or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity : _____

IV. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments: _____

If any of these treatments are going to be provided by another provider of health service (e.g., physical therapist), please state the nature of the treatments: _____

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

V. 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? Yes No

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.) Yes No If yes, please list the essential functions the employee is unable to perform: _____

If neither of the above apply, is it necessary for the employee to be absent from work for treatment Yes No

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

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

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

Authorized Health Care Provider
Name / Address
Telephone Number:



Signature of Authorized Health Care Provider

Date

Type of Practice

Note: See Page 4 for the Definition of a "Serious Health Condition" under the FMLA.

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Definition of a "Serious Health Condition" under FMLA

A "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves 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.

NOTE: 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 therefor, or recovery therefrom.

2. Absence Plus Treatment

Treatment includes examinations to determine if a serious health condition exists and evaluation of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations. A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

- 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 on referral by, a health care provider; or
- Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider. 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 bedrest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a 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:

- 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;
- Continues over an extended period of time (including recurring episodes of a single underlying condition); and
- May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.) but does not necessarily require a visit to a physician at the time of occurrence. For example, a patient with asthma who has been advised to stay home when pollen count is high or a pregnant woman with morning sickness.

5. Permanent/Long-Term Conditions Requiring Supervision

A period of incapacity 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 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 as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy) and kidney disease (dialysis).