CERTIFICATION OF HEALTH CARE PROVIDER

(Family and Medical Leave Act of 1993)

1. Employee's Name: _____

2. Patient's Name (if different from employee): _____

3. Does the patient's condition[1] qualify as a "serious health condition" under any of the categories described under the Family and Medical Leave Act? If so, please check the applicable category.

☐ **Hospital Care (HC)**: inpatient care in a hospital or residential medical care facility, including any period of incapacity[2] or subsequent treatment in connection with or consequent to such inpatient care.

☐ **Absence Plus Treatment (APT)**: a period of incapacity[2] of more than three (3) calendar days (including any subsequent treatment or period of incapacity[2] relating to the same condition), that also involves:

a) treatment[3] two (2) or more times by a health care provider, 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

b) treatment by a health care provider on at least one occasion that results in a regimen of continuing treatment[4] under the supervision of the health care provider.

☐ **Pregnancy (P)**: any period of incapacity[2] due to pregnancy, or for prenatal care.

☐ **Chronic Conditions Requiring Treatments (CC)**: a chronic condition[1] that:

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 continuous period of incapacity[2] (e.g., asthma, diabetes, epilepsy).

☐ **Permanent/Long-term Conditions Requiring Supervision (PC)**: 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 (e.g., Alzheimer's, a severe stroke, or the terminal stages of a disease).

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[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 the inability to work, attend school, or perform other regular daily activities due to the serious health condition, treatment for, or recovery 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.

☐ **Multiple Treatments (Non-chronic Conditions) (MT)**: any period of absence to receive multiple treatments (including any period of recovery from) by a healthcare provider or 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 (3) consecutive calendar days in the absence of medical intervention or treatment, such as cancer (e.g., chemotherapy, radiation), severe arthritis (physical therapy), or kidney disease (dialysis).

☐ **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:

5. a) 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).

   b) 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 for treatment described in MT above)? ☐ Yes ☐ No

   If yes, give the probable duration.

   c) If the condition is a chronic condition (CC) or pregnancy (P), state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity[2].

6. a) 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.

   b) 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.

   c) 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).

7. a) 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

   b) 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.

   c) If neither a nor b applies, is it necessary for the employee to be absent from work for treatment? ☐ Yes ☐ No

8. a) 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 medical or personal needs or safety, or for transportation? ☐ Yes ☐ No

   b) 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

   c) 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

Street Address

Telephone Number

City, State, Zip Code

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

Date