**Certification of Health Care Provider**

1. Employee's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

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

3. The attached definitions describe what is meant by a "**serious health condition**" under the federal and state family and medical leave laws. Does the patient's condition[[1]](#footnote-1) qualify under any of the categories described? If so, please check the applicable category.

 (1)\_\_\_ (2)\_\_\_ (3)\_\_\_ (4)\_\_\_ (5)\_\_\_ (6)\_\_\_, (7)\_\_\_, (8)\_\_\_ or None of the above \_\_\_\_

4. Describe the **medical facts** that 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]](#footnote-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 Item 6 below)? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_

If yes, give the probable duration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and the schedule employee is capable of working: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 c. If the condition is a **chronic condition** or **pregnancy**, state whether the patient is presently incapacitated and the likely duration and frequency of **episodes of incapacity**:

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** or 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** (see attached job description or other information about essential job functions)? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_

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

 c. If the employee is able to perform any of the essential functions of the employee’s job **with limitations and/or accommodations,** please explain those limitations and/or accommodations.

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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and the schedule employee is able to work:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature of Physician) (Type of Practice)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Address) (Telephone number)

*348-1, 4534 am*

1. Here and elsewhere on this form, the information sought relates **only** to the condition for which the employee is taking family/medical leave. [↑](#footnote-ref-1)
2. Here and elsewhere on this form, **"incapacity,"** is defined to mean inability to work, attend school, or perform other regular daily activities due to the serious health condition, treatment for the condition, or recovery from the condition. [↑](#footnote-ref-2)