

CERTIFICATION OF HEALTH CARE PROVIDER FOR FAMILY MEMBER'S SERIOUS HEALTH CONDITION (FAMILY AND MEDICAL LEAVE ACT)

- Incapacity plus Treatment:** (e.g., outpatient surgery, strep throat)
Due to the condition, the patient (has been / is expected to be) incapacitated for *more than three* consecutive, full calendar days from _____ (mm/dd/yyyy) to _____ (mm/dd/yyyy).

The patient (was / will be) seen on the following date(s): _____

The condition (has / has not) also resulted in a course of continuing treatment under the supervision of a health care provider (e.g., prescription medication (other than over-the-counter) or therapy requiring special equipment)

- Pregnancy:** The condition is pregnancy. List the expected delivery date: _____ (mm/dd/yyyy).
- Chronic Conditions:** (e.g. asthma, migraine headaches) Due to the condition, it is medical necessary for the patient to have treatment visits at least twice per year.
- Permanent or Long-Term Conditions:** (e.g. Alzheimer's, terminal stages of cancer) Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).
- Conditions requiring Multiple Treatments:** (e.g. chemotherapy treatments, restorative surgery) Due to the condition, it is medically necessary for the patient to receive multiple treatments.
- None of the above:** If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

- (6) If needed briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. (e.g., use of nebulizer, dialysis): _____

PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage.

- (7) Due to the condition, the patient (had / will have) **planned medical treatment(s)** (schedule medical visits) (e.g., psychotherapy, prenatal appointments) on the following date(s): _____

- (8) Due to the condition, the patient (was / will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: (cardiologist, physical therapy) _____

Provide your **best estimate** of the beginning date _____ (mm/dd/yyyy) and end date _____ (mm/dd/yyyy) for treatments.

Provide your **best estimate** of the duration of the treatment(s), including any period of recovery (e.g., 3 days/week)

- (9) Due to the condition, the patient (was / will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning _____ (mm/dd/yyyy) and end date _____ (mm/dd/yyyy) for the period of incapacity.





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(10) Due to the condition, it (was / is / will be) medically necessary for the employee to be absent from work on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episode of incapacity are estimated to occur _____ times per (day / week / month) and are likely to last approximately _____ (hours / days) per episode.

Signature of Health Care Provider _____ **Date:** _____ (mm/dd/yyyy)

Definitions of a Serious Health Care Condition <i>(See 29 C.F.R. §§ 825.113-.115)</i>
Inpatient Care
<ul style="list-style-type: none"> An overnight stay in a hospital, hospice, or residential medical care facility. Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.
Continuing Treatment by a Health Care Provider (any one or more of the following)
<p>Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either:</p> <ul style="list-style-type: none"> Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
<p>Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.</p>
<p>Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.</p>
<p>Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.</p>
<p>Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.</p>

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.