Certification of Physician or Practitioner (Optional Form WH-380)

Certification of Health Care Provider
(Family Medical Leave Act of 1993)

1. Employee's Name: _____

2. Patient's Name: _____

3. The attached sheet describes what is meant by a "Serious Health Condition" under the Family and Medical Leave Act. Does the patient's condition[1] qualify under any of the categories described here? If so, please check the applicable category.

   1.___ 2.___ 3.___ 4.___ 5.___ 6.___ or 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 the categories in #3.

   _____

   _____

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 take 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)? _____

   If yes, give the probable duration: _____

   c. If the condition is a chronic condition (condition #4) or pregnancy, state whether the patient is presently incapacitated[2] and the like 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? _____

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) _____

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? _____

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? _____

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

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

_____

_____

[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 purpose of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery there from.

PLEASE PRINT OR TYPE

_____	_____
Date form Completed	Name of Health Care Provider
_____	_____
Signature of Health Care Provider	Type of Practice
_____	_____
Telephone Number	Address

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

PLEASE RETURN FORM TO:

Barbara McGuire
Benefit and Compensation Services Manager
142 North Foundation Hall
Oakland University
Rochester, MI 48309

"Serious Health Conditions"

A "Serious Health Condition" means an illness, injury, impairment, or physical or medical 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[1] or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment
   (1) A period of incapacity[1] of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity[1] or subsequent treatment in connection with or consequent to such inpatient care.)
   - (a) **Treatment[2] 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
   - (b) **Treatment** by a health care provider on **at least one occasion** which results in a **regimen of continuing treatment**[3] under the supervision of the 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:
   (1) 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;
   (2) Continues over an **extended period of time** (including recurring episodes of a single underlying condition); and
   (3) 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, 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 or, 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.

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[1] "Incapacity", for purpose of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery there from.

[2] 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.

[3] 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.