MEDICAL CERTIFICATION OF HEALTH CARE PROVIDER

(Family and Medical Leave Act of 1993)

City of Bridgeport
Human Resources Dept.
45 Lyon Terrace, Rm. 223
Bridgeport, CT 06604
(203) 576-7224

When completed, this form goes to the employee, **not to the City of Bridgeport**.

1. Employee's Name	2. Patient's Name (if different from employee)

If this FMLA request is for one's own serious health condition, the qualifying health care provider should complete Sections 3, 4, 5, 6 & 7 below. If it is to care for a parent, spouse or child, please complete Sections 3, 4, 5, 6 & 8.

3. Page 4 describes what is meant by 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_____

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 above:

5. a. State the approximate **date** the serious health condition commenced, and the probable duration of the serious health condition (and also the probable duration of the patient's present **incapacity** if different):

b. Will it be necessary for the employee to **work only intermittently or to work on a less than full schedule** as the result of the serious health condition (including for treatment described in Item 6 below)? If yes, please state the reason for this restriction, its nature, and probable duration:

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 serious health condition, provide an estimate of the probable number of such treatments.

If the patient will be absent from work because of **treatment** on an **intermittent** or **part-time basis**, also provide an estimate of the probable number of 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) and the duration of continuing treatment:

7. a. If a medical leave is required for the employee's own serious health 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 employer will supply you with a job description containing 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 (parent, spouse, or child)** of the employee with a serious health condition, **does the patient require assistance** for basic medical or personal needs or safety, or for transportation? Please explain:

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

Signature of Qualified Health Care Provider

Type of Practice

Address

Telephone Number

City, State, Zip

Date

To be completed by the employee requesting leave to care for a family member:

Describe the type of 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 work schedule:

Employee Signature

Date

Failure to accurately and completely fill out the FMLA application and health care certification may result in a delay in processing and/or approval of an employee's FMLA request. A leave request is not fully processed unless and until it has been approved in writing by the Director of Labor Relations/Human Resources.

A **"Serious Health Condition"** means an illness, injury, impairment, or physical or mental condition that involves one of the following which would prevent an employee from performing the essential functions of his/her position:

1. Hospital Care

   Inpatient care (i.e. 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.

2. Absence Plus Treatment

   A period of incapacity of **more than three (3) consecutive calendar days** (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

   (a) **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 therapy) 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** 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:

   (a) Requires **periodic visits** for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision or 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 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 of, but need not be receiving active treatment** by a health care provider (e.g., Alzheimer's, severe stroke, terminal stages of a disease).

6. Multiple Treatments (Non-Chronic Conditions)

   Any period of absence to receive **multiple treatments** (including any period of recovery there from) 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 or more than three (3) consecutive calendar days in the absence of medical intervention or treatment**.

Serious Health Condition—the information sought relates only to the condition for which the employee is applying for FMLA leave.
Incapacity—for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to and directly related to the serious health condition, treatment thereof, or recovery there from.
Treatments—include examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, dental examinations, or other examinations not directly related to the serious health condition for which the employee is seeking FMLA.
Regimen of continuing treatment—includes, for example, a course of prescription medication 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.

DO NOT SEND THE COMPLETED FORM TO THE EMPLOYER (CITY OF BRIDGEPORT); IT GOES TO THE EMPLOYEE.