The College of St. Scholastica
Request for Family Medical Leave

Employee Name:_____ **Date:**_____

Department:_____ **Position:**_____

Reason for leave request:

Birth/adoption of a child.
Employee: Complete this section only

Due Date:_____
Date leave to start:_____
Date to return to work:_____

Employee serious health condition.
Physician: Complete Parts 1, 2 and 4

Care for a seriously ill family member (spouse, child, parent).

Patient's Name:_____
Relationship to Patient:_____

Physician: Complete Parts 1, 3 and 4

I have read and understand the College's FMLA Leave policy as published in the Employee handbook. (Staff and Faculty Handbooks are published on the College's website)

Employee Signature:_____**Date:**_____

It is your responsibility to ensure this form is filled out completely. Insufficient information could delay the granting of Family and Medical Leave.

If you or your health care provider have questions, feel free to call the Human Resources office at
723-5936 or 723-6602.

This completed form may be faxed to the Human Resources Office at 218-723-6218.

CERTIFICATION OF HEALTH CARE PROVIDER
(Family and Medical Leave Act of 1993)

PART 1 - EXPLANATION OF PATIENT'S HEALTH CONDITION
(Please Print)

1. Employee's Name: _____

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

3. Diagnosis:

4. The attached sheet 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? [ ] Yes [ ] No

   If yes, indicate which one: _____

5. Date condition commenced: _____

6. Probable duration of condition: _____

7. Probable duration of patient's present incapacity: _____

8. Regimen of treatment to be prescribed. (Indicate number of visits, general nature and duration of treatment, including referral to provider of health services. Include schedule of visits or treatment if it is medically necessary for the employee to be off work on an intermittent basis.)

9. Name and title of health care provider that will be administering treatment:

   Name: _____

   Title: _____

   Address: _____

   Phone: _____

PART 2 - CERTIFICATION RELATING TO THE EMPLOYEE'S SERIOUS HEALTH CONDITION

Check **YES** or **NO** in the boxes below, as appropriate.

	YES	NO	
9.	[ ]	[ ]	Is inpatient hospitalization of the employee required?
10.	[ ]	[ ]	Is employee able to perform work of any kind? (If "No", skip Item 11)
11.	[ ]	[ ]	Is employee able to perform the functions of employee's position? (Answer after reviewing statement from employer of essential functions of employee's position, or, if none provided, after discussing with employee.)
12.	[ ]	[ ]	Is it necessary for the employee to be absent from work for treatment of condition?

PART 3 - CERTIFICATION RELATING TO CARE FOR THE EMPLOYEE'S SERIOUSLY-ILL FAMILY MEMBER.

	YES	NO	
13.	[ ]	[ ]	Is inpatient hospitalization of the family member (patient) required?
14.	[ ]	[ ]	Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?
15.	[ ]	[ ]	Is the employee's presence necessary or would it be beneficial for the care of the patient? This may include psychological comfort.

16. Estimate the period of time care is needed or the employee's presence would be beneficial:

PART 4 – PROVIDER VERIFICATION

Signature of Health Care Provider: _____

Address: _____

Telephone Number: _____

Date: _____

Type of Practice (Field of Specialization, if any): _____

_____

(See Next Page)

DEFINITION OF SERIOUS HEALTH CONDITION

"**Serious health condition**" means an illness, injury, impairment, or physical or mental condition that involves either:

- any period of incapacity or treatment connected with inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical-care facility, and any period of incapacity or subsequent treatment in connection with such inpatient care; **or**

- Continuing treatment by a health care provider which includes any period of incapacity (i.e., inability to work, attend school or perform other regular daily activities) due to:

(1) A health condition (including treatment therefore, or recovery there from) lasting more than three consecutive days, and any subsequent treatment or period of incapacity relating to the same condition, that **also** includes:

- treatment two or more times by or under the supervision of a health care provider; **or**
- one treatment by a health care provider with a continuing regimen of treatment; **or**

(2) Pregnancy or prenatal care. A visit to the health care provider is not necessary for each absence; **or**

(3) A chronic serious health condition which continues over an extended period of time, requires periodic visits to a health care provider, and may involve occasional episodes of incapacity (e.g., asthma, diabetes). A visit to a health care provider is not necessary for each absence; **or**

(4) A permanent or long-term condition for which treatment may not be effective (e.g., Alzheimer's, a severe stroke, terminal cancer). Only supervision by a health care provider is required, rather than active treatment; **or**

(5) Any absences to receive multiple treatments for restorative surgery or for a condition which would likely result in a period of incapacity of more than three days if not treated (e.g., chemotherapy or radiation treatments for cancer).

"**Health care provider**" means:

- doctors of medicine or osteopathy authorized to practice medicine or surgery by the state in which the doctors practice; **or**
- podiatrists, dentists, clinical psychologists, optometrists and chiropractors (limited to manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist) authorized to practice, and performing within the scope of their practice, under state law; **or**
- nurse practitioners, nurse-midwives and clinical social workers authorized to practice, and performing within the scope of their practice, as defined under state law; **or**
- Christian Science practitioners listed with the First Church of Christ, Scientist in Boston, Massachusetts; **or**
- Any health care provider recognized by the employer or the employer's group health plan benefits manager.