NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
Certification of Health Care Provider for Family Member's Serious Health Condition Family and Medical Leave Act (FMLA)

SECTION I: For Completion by HHC Representative

Employee's Name: _____

Employee's Title: _____ Hospital or Central Office_____

Work Location_____ Regular work schedule: _____

Employee's essential job functions: _____

_____

SECTION II: For Completion by EMPLOYEE

INSTRUCTIONS to the EMPLOYEE: Please complete Section II before giving this form to your medical provider. Please have your medical provider complete the attached medical certification to care for a covered family member with a serious health condition. Return this form within 15 calendar days of its receipt.

Your name: _____
First Middle Last

Name of family member for whom you will provide care: _____
First Middle Last

Relationship of family member to you: _____

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care:

_____

_____

_____

_____

_____ _____
Employee Signature **Date**

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. 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. Limit your responses to the condition for which the patient needs leave. Page 3 provides space for additional information, should you need it. **Please be sure to sign the form on the last page.**

Provider's name and business address: _____

Type of practice / Medical specialty: _____

Telephone: (_____)_____ Fax:(_____)_____

PART A: MEDICAL FACTS

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
____ No ____Yes. If so, dates of admission: _____

Date(s) you treated the patient for condition: _____

Was medication, other than over-the-counter medication, prescribed? ____No ____Yes.

Will the patient need to have treatment visits at least twice per year due to the condition? ____No ____ Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?
____ No ____Yes. If so, state the nature of such treatments and expected duration of treatment:

_____

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2. Is the medical condition pregnancy? ___No ___Yes. If so, expected delivery date: _____

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

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PART B: AMOUNT OF CARE NEEDED

When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care.

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ____ No ____Yes.

Estimate the beginning and ending dates for the period of incapacity: _____

During this time, will the patient need care? ____ No ____Yes.

Explain the care needed by the patient and why such care is medically necessary:

5. Will the patient require follow-up treatments, including any time for recovery? ____ No ____Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

_____

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Explain the care needed by the patient, and why such care is medically necessary: _____

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6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?

____ No ____Yes.

Estimate the hours the patient needs care on an intermittent basis, if any:

_____ hour(s) per day; _____ days per week from _____ through _____

Explain the care needed by the patient, and why such care is medically necessary:

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7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities?____ No ____ Yes.

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or ___ day(s) per episode

Does the patient need care during these flare-ups? ____ No ____ Yes.

Explain the care needed by the patient, and why such care is medically necessary:

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ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

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Signature of Health Care Provider **Date**