Scott County Family Y
Family and Medical Leave Act (FMLA)
Certification of Health Care Provider for
Employee's Serious Health Condition

SECTION I: For Completion by the Employee

Employee Name: ____

Employer name and contact: ____

Job Title: ____

Essential Job Functions (Attach Your Job Description): ______________________________

____

SECTION II: For Completion by the Health Care Provider

Instructions to the Health Care Provider: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response 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 employee is seeking leave. 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. The last page of the certificate describes what is meant by "serious health condition" under the Family and Medical Leave Act. Does your patient's condition qualify under any of the categories described?

   Check One: _____ YES _____ NO

   Which One(s): _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6

2. Approximate date condition commenced: ____

   Probable duration of condition: ____

Mark below as applicable:

Was the patient admitted for an overnight stay in a hospital, or residential medical care facility?

_____ No _____ Yes

If so, dates of admission: _______________________

Date(s) you treated the patient for condition:

____

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

_____ No _____ Yes

Was medication, other than over-the-counter medication, prescribed?

_____ 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:

____

2. Is the medical condition pregnancy?

_____ No _____ Yes

If so, expected delivery date:

____

4. Use the information provided by the employee in Section I to answer this question.

Is the employee unable to perform any of his/her job functions due to the condition?

_____ No _____ Yes

If so, identify the job functions the employee is unable to perform:

____

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

____

____

____

____

Part B: Amount of leave needed

6. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery?

_____ No _____ Yes

If so, estimate the beginning and ending dates for the period of incapacity:

____

7. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition?

_____ No _____ Yes

If so, are the treatments or the reduced number of hours of work medically necessary?
_____ No _____ Yes

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

____

Estimate the part-time or reduced work schedule the employee needs, if any:

_______ hour(s) per day; _______ days per week from ______ through ______

8. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions?

_____ No _____ Yes

Is it medically necessary for the employee to be absent from work during the flare-ups?

_____ No _____ Yes

If so, explain:

____

____

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

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

____

____

____

____

____

____

____

____

Signature of Health Care Provider **Date**

Return this document to the employee (patient)

SERIOUS HEALTH CONDITION

A **"Serious Health Condition"** means an illness, injury impairment, or physical or mental condition that involves one of the following:

1. **Hospital Care**

   Impatient 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**

   (a) A period of incapacity[1] of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity[1] relating to the same condition), that also involves:

   > **(1) 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
   >
   > **(2) Treatment[2]** 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 Condition 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[1] (e.g., asthma, diabetes, epilepsy, etc.).

5. **Permanent/Long-term Conditions Requiring Supervision**

   A period of incapacity[1] 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.** Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. **Multiple Treatments (Non-Chronic Conditions)**

Any period of absence to receive **multiple treatments**[2] (including any period of recovery therefrom) 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**[1] **of more than three consecutive calendar days in the absence of medical intervention or treatment,** such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

---

[1] **"Incapacity,"** for purposes 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 therefrom.

[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., and 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.