DecisionPEO
The Right Decision

Certification of Health Care Provider

(Family and Medical Leave Act 1993)

1. Employee's Name:_____

2. Patients Name *(if different from employee)*_____

3. Page 4 below 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? 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 these categories.

_____

_____

_____

_____

5.

a. State the approximate **date** the condition commenced and the probable duration of the condition (and the probable duration of the patient's present **incapacity**[2] if different):

_____

_____

_____

b. Will it be necessary for the employee to 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)? ? Yes ? No

If yes, give the probable duration: _____

c. If the condition is chronic (definition - condition # 4) or **pregnancy**, state whether the patient is presently incapacitated [2] and the likely duration and frequency of **episodes of incapacity** [2].

_____

_____

_____

[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 purposes of FMLA) - the inability to work, attend school or perform other regular daily activities due to serious onset of, treatment for or recovery from serious health condition.

6.

a. If additional **treatments** are required, 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 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 or 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 chronic condition), is the employee **unable to perform work** of any kind?

? Yes ? No

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)?

? Yes ? No If yes, please list the essential functions the employee is unable to perform:

c. If neither a or b applies, is it necessary for the employee to be **absent from work for treatment?** ? Yes ? No

8.

a. If leave is required by an employee to **care for a family member with a serious health condition**, does **the patient require assistance** for basic medical or personal needs or safety, or for transportation? ? Yes ? No

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

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

_____

_____ _____

Signature of Health Care Provider Date

_____ (_____)_____

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

Terms and Definitions

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

2. Absence Plus Treatment
(a) A period of incapacity [2] of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity [2] relating to the same condition), that also involves:

(1) **Treatment** [3] **two or more times** by a health care provider, 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** by a health care provider on **at least one occasion** which results in a **regimen of continuing treatment** [4] under the supervision of the health care provider.

3. Pregnancy - Any period of incapacity due to **pregnanc**y, 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 [2] (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-term Conditions Requiring Supervision

A period of **Incapacity** 2 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** (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** 2 **of more than three consecutive calendar days in the absence of medical intervention or treatmen**t, such as cancer chemotherapy, radiation, etc.), severe arthritis (physical therapy), and kidney disease (dialysis).

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.

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.