CERTIFICATION BY EMPLOYEE'S HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS ILLNESS - FMLA

This form is to be completed by employee's Health Care Provider when employee is requesting FMLA and ***medical documentation is required*** *pursuant to 512.41, 513.36 and 515.5 of the ELM.* ***Form PS 3917 must be completed by employee.***

Employee's Name: _____

Description of serious health condition *(On the back of this form is the description of a "serious health condition" under FMLA. 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) _____ None of the above _____

Without giving a specific diagnosis or prognosis, briefly note how the medical facts meet the criteria of the category checked above: _____

Date condition commenced: _____

Probable duration of condition: _____

Probable duration of the present incapacity (if different): _____

Will the employee be required to be off from work intermittently or work on a reduced schedule as a result of this condition and / or treatments? _____ **Note the probable time and duration.**

If the condition is chronic (#4) or pregnancy (#3), note if the employee is presently incapacitated and the likely duration and frequency of episodes of incapacity.

If additional or continuing treatments are required for the condition, provide the nature and regimen of the treatments, an estimate of the probable number of treatments, the length of absence required by the treatments, and the actual or estimated dates of the treatments, if known.

Is the employee able to perform the functions of employee's position? _____ **If no, describe the physical restrictions placed on the employee, including the duration of such restrictions.**

_____ _____

Health Care Provider's Signature ***Date***

Health Care Provider's Address

City, State, ZIP