Principal℠

Completing the FMLA or Leave of Absence Medical Certification FAMILY MEMBER'S SERIOUS HEALTH CONDITION

Instructions for Employee

- □ Notify your manager of your need for absence in accordance with your employer's FMLA and/or leave of absence policies.
- □ Ask your family member's health care provider to complete the Medical Certification and provide it (fax number is below) to Principal Absence Management Center within 15 days of the date this letter was sent.
- □ Consider following up with your family member's health care provider to confirm the Medical Certification was completed and faxed to Principal Absence Management Center, as it is your responsibility to provide a timely, complete and sufficient certification. (Note: You may need to furnish your family member's health care provider with any necessary authorization in order for the health care provider to release a complete and sufficient certification to support the FMLA request.)

Principal Absence Management Center will notify you whether your leave has been approved or denied (via your preferred method of communication - email or postal mail) once we receive a complete and sufficient certification. Alternatively, we will notify you if additional information is required. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request.

Instructions for Health Care Provider

Your patient's family member has requested leave to care for him/her. Please answer fully and completely the two sections on the following pages and sign the form.

Step 1 — PATIENT'S CONDITION. Certify whether your patient has a "serious health condition" as the term is defined under the law (note: for more information on the definition of "serious health condition," you can refer to the U.S. Department of Labor website at http://www.dol.gov/whd/fmla/). Also include information sufficient to establish that the patient is in need of care. If your patient's condition does not meet one of the definitions under the law, please indicate that. Do not provide information related to genetic tests or services.

Step 2 — DATES OF LEAVE. Provide the time needed for leave to care for your patient by his/her family member.

- If the family member's leave is intermittent (described in Step 2) please provide your best estimate of the frequency and duration of the patient's need for care by the family member.
- Terms such as "lifetime," "unknown" or "indeterminate" may not be sufficient to determine whether the patient's condition qualifies for leave.

Step 3 — SIGNATURE. Sign and date the form and provide your type of practice/medical specialty.

Return the completed form via fax to Principal Absence Management Center at 1.877.309.0218 before the listed due date. If you do not complete all steps in full, Principal Absence Management Center will contact you again to cure any deficiencies or your patient's family member's leave may be denied.

For purposes of California: The California Genetic Information Nondiscrimination Act of 2011 (CalGINA) prohibits employers and other covered entities from requesting, or requiring, genetic information of an individual or family member of the individual except as specifically allowed by law. To comply with the Act, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information," as defined by CalGINA, includes information about the individual's or the individual's family member's genetic tests, information regarding the manifestation of a disease or disorder in a family member of the individual, and includes information from genetic services or participation in clinical research that includes genetic services by an individual or any family member of the individual. "Genetic Information" does not include information about an individual's sex or age.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact than an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

FMLA or Leave of Absence Medical Certification
FAMILY MEMBER'S SERIOUS HEALTH CONDITION

Family Member Name:	Patient Name:
Leave Request #:	Family Member's Employer:
Request for leave due to:	**Due Date:**
Family member's requested dates of leave (probable):	
- Continuous leave date range request:	to
- Intermittent leave date range request:	to
- Reduced schedule leave date range request:	to

STEP 1 – PATIENT'S CONDITION.

(A) Describe Appropriate Medical Facts*: Provide a statement or description of appropriate medical facts regarding the patient's health condition for which FMLA leave is requested (i.e., your patient is in need of care by the family member). The medical facts must be sufficient to support the need for leave

**Such medical facts may include information on symptoms, diagnosis, hospitalization, doctor visits, whether medication has been prescribed, and any referrals for evaluation or treatment (physical therapy for example) or any other regimen of continuing treatment such as the use of specialized equipment (Not required in California).*

_____

_____

(B) Select Appropriate Description of Condition. At least one reason from Section 1 or Section 2 must apply to qualify as a serious health condition under the FMLA and/or state law. *At least one section, and all that apply, must be completed.*

Section 1 - A single reason accounts for the patient's need for care:

□ Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility; or any subsequent recovery or treatment in connection with such inpatient care (or, for purposes of California, one who is admitted to a health care facility with the expectation that he or she will remain at least overnight, even if he or she is later discharged such that he/she did not remain overnight).

□ Permanent or long-term condition for which the patient is under continuing supervision of a health care provider but for which treatment may not be effective (e.g., Alzheimer's, a severe stroke)

□ Out of work to undergo multiple treatments and related recovery for one of the below:

(1) restorative surgery after an accident or other injury *or*

(2) a condition that would likely result in a period of incapacity of more than three (3) full, consecutive calendar days in the absence of such treatment.

Section 2—A combination of reasons accounts for the patient's need for care

□ A period of incapacity of more than three (3) consecutive, full calendar days. If so, note the following:

- The dates of any in-person treatments within the first 30 days of the patient's incapacity (if not provided by you, please note the medical specialty of the treating provider, e.g., nurse, physical therapist)

  _____

- The number, if any, of regimens of continuing treatment prescribed within the first 30 days of the patient's incapacity by, under the supervision of, or referred by a health care provider:

  _____

□ A chronic health condition which continues over an extended period of time and BOTH:

(1) requires periodic visits for treatment by a health care provider (at least two (2) visits per year) and

(2) may cause episodic incapacity or flare-ups or would cause periods of reoccurrence without treatment (*e.g.* asthma, diabetes, epilepsy, *etc.*)

Section 3 - The patient does not have a qualifying serious health condition

□ None of the reasons in Section A or Section B apply.

(C) Explain the care needed by patient and why the care by the family member is medically necessary. Why is the employee needed to care for the family member?

_____

_____

STEP 2 – DATES OF LEAVE. Consider all dates the family member will need to miss work because he/she is needed to care for your patient by completing the applicable sections below. Dates requested by the family member are listed above. *At least one section, and all that apply, must be completed.* ***Answers of "unknown," "indeterminate" or "lifelong" may not be sufficient to determine FMLA coverage.***

□ **Continuous Leave:**

Is the patient in need of care by the family member for a single, continuous period of time?

i. Start date of need for care____ / ____ / _____ (DD/MM/YYYY)
ii. Estimated end date of need for care ____ / ____ / _____(DD/MM/YYYY)
iii. Will the patient require follow-up appointments for which his/her family member is needed? *If so, please indicate the frequency of incapacity below in section iii under "Intermittent Leave".*

□ **Intermittent Leave:**

Does the patient's illness or injury require this family member to take occasional time off work?

i. Start date for leave or initial appointment date
____ / ____ / _____ (DD/MM/YYYY)
ii. Probable end date for leave
____ / ____ / _____(DD/MM/YYYY) *or*
□ Condition is lifelong (check if applicable)
iii. **Appointments/treatments -** Will the family member need to miss work for appointments or treatments?
a. □ No
a. □ Yes – Estimate treatment schedule:
- Frequency: Up to _____times per _____ (week, month, or year)
Duration: Up to _____ (hours or days)

b. Please include the dates of any scheduled appointments and the time required for each appointment:
_____

iv. **Flare-ups/Episodes -** Will the employee need to miss work to care for the patient during episodes of incapacity/flare-ups of the health condition?
b. □ No
c. □ Yes – Estimate of absences for appointments or treatments for which this family member is needed?
- Frequency: Episodes may occur up to _____times per _____ (week, month, or year)
Duration: Each episode may last up to _____(hours

AND/OR

□ **Reduced Schedule Leave:**

Does the patient's condition require the family member to work on a FIXED part-time schedule or take predictable regularly scheduled absences to care for them?

Start Date of Leave:
____ / ____ / _____
(DD/MM/YYYY)
Probable End Date of Leave:
____ / ____ / _____
(DD/MM/YYYY)

Su	
M	
Tu	
W	
Th	
F	
Sa	

(Number of hours patient needs care by this family member each day)

STEP 3 – SIGNATURE. Health Care Provider Information:

Name:

Practice/Specialty/Credentials:

Street Address:

Fax Number:

City, State, ZIP Code

Signature:

Phone Number:

Date:

Phone: 877-734-3652 **Fax:** 877-309-0218
Principal Absence Management Center Email: LeaveCenter@principal.absencemgmt.com
To mail: Principal Absence Management Center, 455 N. Cityfront Plaza Drive, Chicago, IL 60611-5322

GINA prohibits employers from requesting genetic information. See instructions on first page.