Principal℠

Completing the FMLA or Leave of Absence Medical Certification EMPLOYEE'S OWN SERIOUS HEALTH CONDITION

Instructions for Employee

- □ Notify your manager of your need for leave of absence (in accordance with your employer's FMLA and/or leave of absence policies.)
- □ Ask your health care provider to complete the Medical Certification and provide it (fax number is below) to Principal Absence Management Center within 15 calendar days
- □ Consider following up with your health care provider to confirm the Medical Certification was completed and faxed to Principal Absence Management Center, it is your responsibility to provide timely, complete and sufficient certification. (Note: you may need to furnish your 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

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 cannot perform the essential functions of his/her job as well as the nature of any other work restrictions, and the likely duration of such inability. 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 frequency and probable dates needed for leave.

- Consider **all of the dates** that your patient has had or will have to be out of work due to the serious health condition, even if the patient was initially treated by someone else (e.g., in an emergency room or ICU).
- If your patient's leave is intermittent (described in Step 2) **please provide your *best estimate*** of the frequency and duration of the patient's condition, treatments, etc.
- Terms such as "lifetime," "unknown" or "indeterminate" **may not be sufficient** to determine whether the patient's condition qualifies for a leave.

Step 3 — SIGNATURE. Sign 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 and return it before the due date, your patient'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
EMPLOYEE'S OWN SERIOUS HEALTH CONDITION

Employee/Patient Name: Employer:
Leave Request #: **Due Date:**
Request for leave due to: Employee's own serious health condition
Dates of leave (probable) requested by employee/patient:
- 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., leave is medically necessary). 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, 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 medically necessary absence from work:

□ 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, an employee 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 medically necessary absence from work:

□ Unable to work/perform job duties for <u>more than</u> 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 employee'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 employee'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) <u>and</u>
(2) may cause episodic incapacity or flare-ups or would cause periods of reoccurrence without treatment (*e.g.* asthma, diabetes, epilepsy, *etc.*)

The patient does not have a qualifying serious health condition:

□ None of the reasons in Section 1 or Section 2 account for the patient's absence from work

(C) Confirm employee cannot perform the essential functions of the job.
Your patient should provide you with a description of his/her job functions.
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 and the nature of the work restrictions and the duration of such inability: _____

STEP 2 – DATES OF LEAVE. Consider all dates the patient has been or will be unable to work by checking and completing either of the below sections that apply. Dates requested by the patient 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 unable to work for a single, continuous period of time?*

i. Start date of incapacity ____ / ____ / _____ (DD/MM/YYYY)
ii. Estimated end date of incapacity ____ / ____ / _____(DD/MM/YYYY)
iii. Will the employee require follow-up appointments? *If so, please indicate the frequency of incapacity below in section iii under "Intermittent Leave" as well as any past treatment dates in section v.*

□ **Intermittent Leave:**
Is the patient is able to work but needs occasional time off for a single illness or injury?

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 patient need to miss work for appointments or treatments?
a. □ No
b. □ Yes – Estimate treatment schedule:
- Frequency: Up to _____times per _____ (week, month, or year)
Duration: Up to _____ (hours or days)

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

iv. **Flare-ups/Episodes -** Will the patient need to miss work for episodes of incapacity/flare-ups of the health condition?
a. □ No
b. □ Yes – Estimate of absences needed for episodes:
- Frequency: May occur up to _____times per _____ (week, month, or year)
Duration: May last up to _____(hours or days)

v. Dates you have already treated the patient for the condition:

AND/OR

□ **Reduced Schedule Leave:**
Is the patient working on a <u>FIXED</u> part-time schedule or taking predictable regularly scheduled absences?

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

Su	
M	
Tu	
W	
Th	
F	
Sa	

(Please indicate the hours of time the patient will need to miss each day)

STEP 3 – SIGNATURE. Health Care Provider Information:

Name:

Practice/Specialty and 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.