CERTIFICATION OF HEALTH CARE PROVIDER
(Family and Medical Leave Act of 1993)

TO BE COMPLETED BY THE EMPLOYEE:

Employment Category: ☐ Non – Ops (Not a train service employee) ☐ Train service Western Region
☐ Train service Southern Region ☐ Train service Northern Region

Employee's Name: Job Title:

Employee's Phone Number: Service Unit or Department:

Employee ID: Supervisor:

Reason for leave: ☐ Birth of an employee's Child (Estimated due date _____)
☐ Own Serious Health Condition
Care of: ☐ Parent ☐ Spouse ☐ Child (age _____)

Type of Leave: ☐ Block ☐ Intermittent ☐ Reduced Work Schedule

Qualified employees have a right under the Family and Medical Leave Act of 1993 (FMLA) for up to 12 weeks of unpaid leave during the calendar year for reasons listed above. By signing this form I agree to allow a Health Care Provider representing Union Pacific to contact my Health Care Provider, if necessary, for purposes of clarification and authenticity of the medical certification. Both I and/or my family member certify that this request is truthful and accurate to the best of our knowledge.

Employee's Signature _____ Date _____

Family Member's Signature _____ Date _____

TO BE COMPLETED BY THE HEALTH CARE PROVIDER:

Patient's Name:

Relationship to Employee: If patient is employee's child - age:

1. Does the patient's condition qualify as a "serious health condition?" **(Definitions of a serious health condition are located on page 3)**
   ☐ No. Does not have a "serious health condition"
   ☐ Yes has a "serious health condition", **(check the category or categories the patient's condition qualifies under)**
   - ☐ 1. Hospital Care – Admission Date: _____ Release/Estimated Release Date: _____
   - ☐ 2. Absence Plus Treatment
   - ☐ 3. Pregnancy (EDC: _____)
   - ☐ 4. Chronic Conditions Requiring Treatment
   - ☐ 5. Permanent/Long Term Incapacity
   - ☐ 6. Multiple Treatments

2. Date the condition commenced: _____ Probable duration of the condition: _____

3. **Describe** the medical facts which support the certification of the **patient's** serious health condition as defined by the categories above

4. Condition or Need for Care requires employee to take:
   ☐ **Block Leave** – (a one-time continuous block of leave)
   Incapacity* Commenced: _____ Probable duration of Incapacity*: _____
   ☐ **Intermittent Leave** - (periodic absences due to periods of incapacity or for treatment** necessitated by the condition)
   Need for Leave Commenced: _____ Probable duration of the need for leave: _____
   ☐ **Reduced Work Schedule** - (reduction in the employee's normal work day or work week)
   Start Date: _____ Estimated End Date: _____
   Describe specific work schedule limitations:

5. **Describe** the **medical necessity** of the leave if leave is to be taken intermittently or on a reduced work schedule:

Return to: Union Pacific Railroad - Health and Medical Department - 1400 Douglas St. Stop 0350 - Omaha, NE 68179
OR Fax to: 402-501-0067

Employee Name: _____ Employee ID: _____

Form 16874
Rev. 10/06

CERTIFICATION OF HEALTH CARE PROVIDER Cont.

(Family and Medical Leave Act of 1993)

6. Does the **patient** experience incapacity* due to the serious health condition such as the inability to work or perform the essential functions of their job, attend school or daycare, and/or perform regular daily activities? ..... □ Yes □ No
   - Is the patient's incapacity □ Continuous or □ Periodic?
   - If the incapacity is periodic, based upon your knowledge of the patient's health history:
     How often does the patient generally experience incapacity? _____
     How long do the periods of incapacity generally last? _____

7. Did the patient have an office visit? ..... □ Yes □ No
   If yes, date or dates of visit(s):
   Scheduled or expected follow up visit(s):

8. Does the patient have periodic visits to diagnose, monitor or treat their condition (not including routine physical, eye or dental examinations)? ..... □ Yes □ No
   If yes, what is the interval of visits?

9. If treatment is required for the condition, **describe the current treatment plan** (e.g., prescription drugs or therapy including treatment provided by another Health Care Provider):

   a. Date current treatment began: _____
   b. The prescribed duration of treatment: _____
   c. The estimated number of treatments: _____
   d. The Approximate interval of treatments: _____
   e. Recovery period due to treatment required: _____

10. Is it necessary for the employee to be absent from work to attend treatments? ☐ Yes ☐ No

11. Describe the patient's **"Need For Care"**

- Is the family member unable to care for his/her own **basic medical** or personal needs such as **nutrition** or **hygiene**? □ Yes □ No
  Explain:
- Does the family member require assistance with **safety**? ☐ Yes ☐ No
  Explain:
- Is the family member **unable to transport him/her self** to the health care provider? ☐ Yes ☐ No
  Explain:
- If the family member is receiving **inpatient** or **in home care**, is the employee needed to provide psychological care and comfort to the family member? ☐ Not applicable ☐ Yes ☐ No
  Explain:

12. What is the probable amount of time required providing care as described in question 11?

HEALTH CARE PROVIDER INFORMATION

Name (please print):		Type of Practice:
Clinic / Hospital:		Area Code and Phone Number:
Address		Fax Number:
City:	State:	Zip Code:
Signature:		Date:

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

(1) **Treatment** ** **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** by a health care provider on **at least one occasion** which results in a **regimen of continuing treatment**** under the supervision of the health care provider.

3. Pregnancy

Any period of incapacity due to **pregnancy,** 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* *(e.g.,* asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-term Conditions Requiring Supervision

A period of **Incapacity*** 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, other 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* 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), and kidney disease (dialysis).

* "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 therefor or recovery therefrom.

** 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

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This form is a substitute for the DOL certification prepared by Union Pacific under the authority of 29 CFR 825.306, and may be used by employees to satisfy a mandatory requirement to furnish a medical certification (when requested) from a health care provider, including second or third opinions and recertification.