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FMLA CERTIFICATION OF HEALTHCARE PROVIDER FORM

(The Family and Medical Leave Act of 1993)

TO BE COMPLETED BY THE HEALTHCARE PROVIDER AND FAXED TO:

Randall Cumbaa
Sr. Human Resources Associate
Emory University Human Resources
Voice: 404-727-1209
Fax: 404-727-2716 or 1-866-207-9998
(Numbers are HIPPA compliant)

1. Employee's Name:	2. Patient's Name (If different from employee and relationship to employee)

3. Page 4 describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition1 qualify under any of the categories described? Yes ☐ No ☐

   If so, please check the applicable category: (1) ☐ (2) ☐ (3) ☐ (4) ☐ (5) ☐ (6)

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, the probable duration of the condition, and the probable duration of the patient's present incapacity2, if different. _____

   (b) Will it be necessary for the employee to take work intermittently or to work a reduced schedule as a result of the condition (including for treatment described in 6 below)? _____

   If yes, give the probable duration: _____

   (c) If the condition is a chronic condition (condition 4) or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity: _____

[1] ***Here, and elsewhere on this form, the information relates only to the condition for which the employee is taking FMLA Leave.***

[2] ***"Incapacity," for purposes of FMLA, is defined to mean inability to work, attend school, or perform other regular daily activities because of the serious health condition, treatment therefore, or recovery there from.***

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6. (a) If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments. _____

_____

_____

(b) If the patient will be absent from work or other daily activities because of treatment3 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. _____

_____

_____

(c) If any of these treatments will be provided by another provider of health services (e.g., physical therapist), please state the nature of the treatments. _____

_____

_____

(d) If a regimen of continuing treatment4 by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs or 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 a 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 ☐ (If yes, please list the essential functions the employee is unable to perform.) No ☐ _____

_____

_____

_____

(c) If neither (a) nor (b) applies, is it necessary for the employee to be absent from work for treatment?
Yes ☐ No ☐

[3] ***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.***

[4] ***A regimen of continuing treatment includes 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 healthcare provider.***

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8. (a) If leave is required to care for a family member of the employee 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 provide psychological comfort or be beneficial to the patient or assist in the patient's recovery? _____

(c) If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need. _____

Healthcare Providers' Signature | Type of Practice

Name of Healthcare Provider (Please Print) | Telephone Number

Street Address | City/State | Date

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's Signature | Date

Note: It is the employee's responsibility to ensure that the healthcare provider fully completes this form.

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DEFINITION OF A SERIOUS HEALTH CONDITION

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 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:

   (a) Treatment3 two or more times by a healthcare provider, by a nurse or physician's assistant under direct supervision of a healthcare provider, or by a provider of healthcare services (e.g., physical therapist) under orders of, or on referral by, a healthcare provider; or

   (b) Treatment by a healthcare provider on at least one occasion which results in a regimen of continuing treatment4 under the supervision of the healthcare provider.

3. **Pregnancy**

   Any period of incapacity due to pregnancy or prenatal care.

4. **Chronic Conditions Requiring Treatments**

   A chronic condition which:

   (a) Requires periodic visits for treatment by a healthcare provider, or by a nurse or physician's assistant under direct supervision of a healthcare provider;

   (b) Continues over an extended period of time, including recurring episodes of a single underlying condition;

   and,

   (c) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes or epilepsy).

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 healthcare 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 there from) by a healthcare provider or by a provider of healthcare services under orders of, or on referral by, a healthcare 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), or kidney disease (dialysis).