

Certification of Health Care Provider *(Family and Medical Leave Act of 1993)*

*** To Be Completed by Health Care Provider ***

1. **Employee Name:**

2. **Patient's Name:** *(If different from employee)*

3. Attached is a sheet which describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition qualify under any of the categories described? If yes, please indicate the applicable category:

- Hospital Care
- Absence From Work (4 or More Days) Plus Treatment
- Pregnancy
- Chronic Condition Requiring Treatment
- Permanent/Long-term Condition Requiring Supervision
- Multiple Treatments (Non-Chronic Condition)

4. Type of leave the Employee will need to take:

- Continuous
- Intermittent / Periodic
- Reduced Work Schedule
- Medical Appointments Only

5. Describe the medical facts which support your certification and a brief statement as to how the patient's condition meets the criteria of one of these categories:

6. Beginning Date of Leave: _____ End Date, if Known: _____

7. If the employee is currently incapacitated, please state the anticipated duration of the current incapacity:

8. If the condition will require the employee to be absent from work intermittently or to work a reduced schedule, state the likely frequency and duration of future episodes of incapacity (e.g., will the employee need several days each month, a full day, several hours, certain times of day, etc.):

9. If a regimen of continuing treatment is required for the patient, provide a general description of such regimen (e.g., prescription drugs, physical therapy, etc.):

10. If future treatments will be required for the condition, provide an estimate of the probable number and duration of such treatments, actual or estimated dates of treatment and period required for recovery, if any:

Are treatment appointments available outside the employee's scheduled working hours? Yes [] No []

11. If any of these treatments will be provided by another provider of health services (e.g. physical therapist), state the nature and frequency of the treatments:

12. If able to perform work, is the employee able to perform all of the essential functions of his/her job? (The employee should provide you with the information about the essential job functions) Yes [] No []

If no, list the essential functions the employee is unable to perform and the anticipated duration:

If leave is required to care for a family member with a serious health condition, complete the following:

13. Does the patient require assistance for basic medical or personal needs or safety, or for transportation? Yes [] No []

14. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? Yes [] No []

15. If the patient will need care only intermittently or on a part-time basis, indicate the probable duration and frequency of this need:

Signature of Health Care Provider

Date

Name of Health Care Provider *(Please Print)*

Type of Practice

Address

Telephone Number

**To Be Completed by Employee
Only When Leave Is Needed 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 Signature

Date

Definition of "Serious Health Condition"

(Explanation of Categories)

Serious Health Condition - an illness, injury, impairment, or physical or mental condition that involves one of the following:

Hospital Care	Inpatient care (e.g., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity ¹ or subsequent treatment in connection with or consequent to such inpatient care.
Absence Plus Treatment	A period of incapacity ¹ of four or more consecutive calendar days (including any subsequent treatment or period of incapacity relating to same condition), that also involves: <ul style="list-style-type: none"> a. Treatment (including examinations to determine and evaluate the condition) two or more times by 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 b. Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment² (e.g., course of prescription medication or therapy) under the supervision of the health care provider.
Pregnancy	Any period of incapacity due to pregnancy, pregnancy complications, or for prenatal care.
Chronic Conditions Requiring Treatments	A chronic condition which: <ul style="list-style-type: none"> a. 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; b. Continues over an extended period of time (including recurring episodes of a single underlying condition); and c. May cause episodic periods of incapacity¹ rather than a continuing period (e.g., asthma, diabetes, epilepsy, migraine headaches, depression, etc.)
Permanent/Long Term Conditions Requiring Supervision	A period of incapacity ¹ 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, or the terminal stages of a disease.
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 ¹ of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation treatment, etc.), severe arthritis (physical therapy), and kidney disease (dialysis).

¹ "Incapacity" for purposes of the FMLA, is defined to mean inability to work, attend school, or perform other regular daily activities due to the serious health condition, treatment therefor, and recovery therefrom.

² A regimen of continuing treatment includes a course of prescription medication or therapy requiring special equipment to resolve or alleviate the health condition. It does not include the taking of over-the-counter medications, bed rest, drinking fluids, exercise, or other similar activities that can be initiated without a visit to a health care provider.