# HEALTH CARE PROVIDER CERTIFICATION OF EMPLOYEE'S FAMILY MEMBER ILLNESS-FMLA

**Employee's name**

**Patient's name**

**Relationship to employee** ____Spouse ____ Parent ____ Child *(under age 18 or older and incapable of self care due to a mental or physical disability)*

**Description of serious health condition** *(On the back of this form is the description of a "serious health condition" under FMLA. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category.)*

(1) ____ (2) ____ (3) ____ (4) ____ (5) ____ (6) ____ None of the above ____

**Without giving a specific diagnosis or prognosis, briefly note how the medical facts meet the criteria of the category checked above.**

**Date condition commenced:**

**Probable duration of condition:**

**Probable duration of the present incapacity (if different):**

**Will the employee be required to be off from work intermittently or work on a reduced schedule as a result of the patient's condition and /or treatments? _____ Note the probable time and duration.**

**If the condition is chronic (#4) or pregnancy (#3), note if the patient is presently incapacitated (inability to perform regular daily activities) and the likely duration and frequency of episodes of incapacity.**

**If additional or continuing treatments are required for the condition, provide the nature and regimen of the treatments, an estimate of the probable number of treatments, the length of absence required by the treatments, and the actual or estimated dates of the treatments, if known.**

**Does the patient require assistance for basic medical, hygiene, nutritional needs, safety, or transportation? If no, would the employee's presence to provide psychological comfort be beneficial to the patient's recovery? _____ Note the probable duration of the need.**

**Health Care Provider's Signature** **Date**

**Address**

# FMLA DESCRIPTION OF SERIOUS HEALTH CONDITION[1]

**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[2] 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) *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**
**(b) *Treatment* by a health care provider on *at /east one occasion* which results in a *regimen* of continuing *treatment*[3] 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;**

**(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* rather than a continuing period of incapacity" (e.g., *asthma, diabetes, epilepsy).***

## 5. Permanent/Long-term Conditions Requiring Supervision

**A period of incapacity4 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.**

## 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[4] 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), kidney disease (dialysis).**

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

[2] 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.

[3] 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.

[4] "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.