CERTIFICATION OF EMPLOYEE'S SERIOUS HEALTH CONDITION FOR FAMILY AND MEDICAL LEAVE

This form must be completed by a Health Care Provider when FMLA leave is requested and medical documentation is required, pursuant to 512.41, 513.36 and 515.5 of ELM. **In all instances the information on the form must relate only to the serious health condition for which the current need for leave exists.** ***Form PS 3971 also must be completed by employee and submitted to properly request FMLA leave.*** *PLEASE REVIEW THE FORM AND COMPLETE ALL SECTIONS THAT APPLY. FAILURE TO PROVIDE COMPLETE INFORMATION COULD RESULT IN DELAY OR DENIAL OF LEAVE REQUEST.*

I. EMPLOYEE INFORMATION

Employee's Name: _____

EIN: _____ FMLA Case # _____

II. CONDITION REQUIRING LEAVE

Please check the box below for the type of serious health condition the Employee has. ***See page 3 for a complete description of what constitutes a "serious health condition" for purposes of the FMLA.***

☐ 1. **Hospital Care**
☐ 2. **Absence Plus Treatment**
☐ 3. **Pregnancy**
☐ 4. **Chronic Condition**
☐ 5. **Permanent Long-term Condition**
☐ 6. **Multiple Treatments** (Non-Chronic Condition)

Describe the medical facts and/or treatment that meet the criteria of the serious health condition checked above. This may include symptoms, nature of the condition, dates of treatment, or any regimen of continuing treatment such as a course of prescription medication or therapy requiring use of specialized medical equipment. ***Medical diagnosis/prognosis is not required***. **Note For Chiropractors**: Under the FMLA, a serious health condition involving chiropractic treatment is limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist. No X-rays are needed, but a statement that a subluxation was identified by X-rays should be provided.

_____

_____

_____

III. DURATION AND EXTENT OF LEAVE REQUIRED

What is the date the condition commenced? _____

On which dates did you treat the Employee in the past 12 months? _____

How long do you project the condition to continue? _____

How long will the employee be incapacitated (if different)? _____

How long will the employee need to be on leave because of the condition? _____

_____

Will the employee need treatment at least twice per year for the condition? ☐ Yes ☐ No

Will the employee require intermittent leave or a reduced work schedule due either to planned medical treatment (for example, follow-up visits or physical therapy), or because of unforeseeable episodes of incapacity (for example, flare ups of symptoms)? ☐ Yes ☐ No

If yes, please provide the following additional information:

Estimated dates of scheduled treatment: _____

Frequency of treatment/episodes of incapacity: ___ times per ___week ___ month

Duration of treatment/episode of incapacity: ____hour(s) or ____ day(s)
(for example, 3 times per 1 month lasting 1-2 days per episode)

Period of Recovery: _____

Is the employee able to perform the essential functions of the employee's position without physical restrictions, accommodations or modification of job duties? ☐ Yes ☐ No

If no, can the employee perform the essential functions of the job with physical restrictions, accommodations or modifications of job duties? ☐ Yes ☐ No

If yes, describe the physical restrictions, accommodations or modification of job duties required: _____

_____

_____

IV. HEALTH CARE PROVIDER SIGNATURE

Dated: _____ By: _____

Health Care Provider's Name (Please print): _____

Address: _____

Telephone Number: _____Fax Number: _____

Specialty/Type of Practice: _____

FMLA DESCRIPTION OF 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 full consecutive days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:
a) Treatment two or more times (within 30 days of the first day of incapacity, unless extenuating circumstances exist) 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,
(b) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of a health care provider.
The requirements for treatment by a health care provider means an in-person visit to a healthcare provider.
The first (or only) in-person treatment visit must take place within seven days of the first day of incapacity.

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 (at least twice a year) 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 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, 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 incapacity4 of more than three full 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).

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. antibiotic) or therapy requiring special equipment to restore or alleviate the health condition. A regimen of continuing 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.
"Incapacity," for purposes of FMLA, Incapacity is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.