

SECTION 1 - TO BE COMPLETED BY THE EMPLOYEE

Employee’s Last Name	First Name	Middle Initial	Date of Injury/Illness
Title		Department	Supervisor

Section 2 - To Be Completed By A Physician Or Other Health Care Provider

This individual is employed by The Research Foundation of The State University of New York. His/her presence at work is required and necessary. The Human Resources Department is committed to working with employees, their supervisors and physicians to bring an employee back to work as soon as reasonably possible. Please certify if the employee noted above is physically or mentally incapacitated from performing work of any kind. **The following information is required before the employee can charge his/her sick leave credits and/or have his/her absence from work designated as Family Medical Leave Act (FMLA) leave.**

The reverse side of this form describes what is meant by a “serious health condition” under the FMLA.

1. Is it your opinion that the employee’s condition qualifies under any of the categories described on the reverse side of this form? Yes No
If YES, please check the applicable category: 1 2 3 4 5 6
2. Is this injury or illness work-related? Yes No
3. Describe the **medical facts** that support your certification. (If injury/illness is work-related or employee is charging sick leave credits, please provide diagnosis):

4. Medication and/or treatment prescribed: _____

5. State the date the condition commenced: _____
Estimate the probable duration of the condition: _____
Could the injury, illness or condition result in a permanent restriction or loss of function? Yes No
If YES, please explain: _____

6. When will s/he be seen again? _____

7. Is it medically necessary for this employee to be absent from work? Yes No If YES, please check the appropriate box below:
 Continuous absence from _____ to _____
 Intermittent absence(s) from _____ to _____
If intermittent absences are required, please explain: _____

8. If this employee is being released to return to work, as of what date can s/he return? (date) _____
Are work restrictions necessary? Yes No If YES, please provide:
Specific work restriction(s): _____

Begin date for restriction(s): _____ End date for restriction(s): _____

Physician’s Name (Please Print): _____ Type of Practice/Specialty: _____

Physician’s Address: _____

Telephone Number: _____ Fax Number: _____

Physician’s Signature: _____ Date: _____

Section 3 - I authorize my physician/healthcare provider to release information relating to the injury/illness noted above and his/her treatment thereof to my employer.

Employee 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 as a consequence of, such inpatient care.
- 2. Absence Plus Treatment:** A period of incapacity of more than three consecutive calendar days (including any subsequent treatment of period of incapacity relating to the same condition that also involves:
 - a. Treatment of two or more times by a health care provider, 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. Treatments by a health care provider on at least one occasion that result 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 that:
 - a. Requires period visits for treatment by a health care provider or a nurse or physician’s assistant under direct supervision of the health care provider;
 - b. Continues over an extended period of time (including recurring episodes of a single underlying condition); and
 - c. May cause episodic incapacity rather than a continuing period of incapacity (e.g. asthma, diabetes, epilepsy, etc.).
- 5. Permanent/Long-term Conditions Requiring Supervision:** A period of incapacity that is permanent or long term due to a condition for which treatment may not be effective. The employee (or employee’s family member) must be under the continuing supervision of, but need not be receiving active treatment from, a health care provider. Examples include Alzheimer’s, a severe stroke, or the terminal stages of disease.
- 6. Multiple Treatments (Non-chronic Conditions):** Any period of absence to receive multiple treatment (including any period of recovery from them) by a health care provider or 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 be likely to 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).