



SECTION 1 - TO BE COMPLETED BY THE EMPLOYEE

Employee’s Last Name _____ First Name _____ Middle Initial _____ Date of Injury/Illness _____

Patient’s Name _____ Relationship to Employee _____

When Family Medical and Leave Act is needed to care for a seriously ill family member, the employee will state the care s/he will provide and an estimate of the time period during which care will be provided. If it is medically necessary for the employee to be off work on an intermittent basis or to work less than the employee’s normal work schedule in order to care for the seriously ill family member, the employee must provide a schedule of requested leave days.

Employee Signature: _____ Date: _____

SECTION 2 - TO BE COMPLETED BY A PHYSICIAN OR OTHER HEALTH CARE PROVIDER

The reverse side describes what is meant by a “serious health condition” as defined under the Family and Medical Leave Act.

- Does the family member’s condition qualify 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
- Describe the medical facts that support your certification. (If the employee is charging sick leave credits, please provide diagnosis).

- Indicate regiment of treatment prescribed. Please include the following information: The number of visits, general nature and duration of treatment, any referrals you have made to other health care providers and a schedule of visits or treatments if not is it medically necessary for the employee to be off work on an intermittent basis or to work less than the employee’s normal work schedule in order to care for a seriously ill family member.

- Date condition commenced: _____ Probable Duration: _____
- Please estimate the period of time the employee’s presence will be needed/beneficial. (This may include providing psychological comfort.):

- If intermittent absences are required, please explain: _____

- Is inpatient hospitalization of the family member (patient) required? Yes No
Does (or will) the patient require assistance for basic medical, hygiene or nutritional needs? Yes No
Does (or will) the patient require assistance for safety or transportation needs? Yes No

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

Physician’s Address: _____

Telephone Number: _____ Fax Number: _____

Physician’s Signature: _____ Date: _____

Section 4– I authorize my physician/healthcare provider to release information relating to the illness noted above and his/her treatment thereof to my family member’s 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).