CERTIFICATION OF HEALTH CARE PROVIDER
Family and Medical Leave Act of 1993 (FMLA)
DEACONESS

This Section to be completed by the employee and then submitted to the patient's health care provider.

EMPLOYEE'S NAME (Print)_____ Job Title _____

List Your Essential Job Functions: _____

_____

If 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 your regular schedule:

_____

_____

_____

EMPLOYEE SIGNATURE_____ Date_____

THIS SECTION TO BE COMPLETED BY HEALTH CARE PROVIDER

This section is to be completed by the patient's health care provider and returned to the Human Resources Department of Deaconess <u>within 15 days from request from employer</u>.

Patient's Name and Relationship to Employee (include age for dependent child):_____

On the reverse of this form are categories that describe what is meant by a **"serious health condition"** under the Family and Medical Leave Act. Please check the applicable category for the patient.

(1)_____ (2a)_____ (2b)_____ (3)_____ (4)_____ (5)_____ (6)_____

Date Patient Seen by Health Care Provider for this Condition:_____
(**<u>Must be seen within 7 days of first day of incapacity</u>**)
Presently Incapacitated? ☐Yes ☐No

For Chronic Condition, List Duration and Frequency of Episodes_____

Start Date of Leave:_____ For Maternity-Estimated Due Date:_____

Expected Date of Return to Work:_____

DIAGNOSIS: Include supporting medical facts, treatment **and** medications needed, and any work restrictions including intermittent or reduced schedule leave:_____

_____
_____

_____

Is the patient unable to perform their essential job functions, as described above, due to this **"serious health condition"**? ☐**YES** ☐**NO**

_____ Date_____
Signature of Health Care Provider/Type of Practice

If you would like to make additional comments, please use the space provided on the reverse of this form.

F-3006* (5-09)

FMLA CATEGORIES OF A SERIOUS HEALTH CONDITION

1. Inpatient Care - any period of incapacity or any subsequent treatment due to such care.
2. Absence plus treatment by a health care provider - Any period of incapacity of **three full** consecutive calendar days (and any subsequent treatment or period of incapacity relating to the same condition), that also involves:
   a. **In-person treatment within 7 days of the first day of incapacity and a second in-person visit within 30 days by or under the direction of a health care provider; or**
   b. **In-person treatment within 7 days of the first day of incapacity by or under the direction of a health care provider that results in a regimen of continuing supervised treatment**.
3. Pregnancy - any period of incapacity due to pregnancy, or for prenatal care.
4. Chronic conditions - requires periodic visits, continues over an extended period of time, and may cause episodic rather than a continuing period of incapacity.
5. Permanent/long term conditions - incapacity for which treatment may not be effective.
6. Multiple treatments (non-chronic conditions) - any period of absence to receive multiple treatments by a health care provider for restorative surgery after an accident or injury that would result in absence of at least four consecutive calendar days if left untreated.

EXAMPLES

A serious health condition would likely include the following:

- Heart attack
- Most cancers
- Back conditions requiring extensive therapy or surgery
- Appendicitis
- Pneumonia
- Ongoing Pregnancy
- Severe arthritis
- Miscarriage
- Physical examinations to determine if a serious health condition exists and evaluations of the condition
- Treatment for allergies, mental illness resulting from stress or substance abuse if all conditions are met (but the employer still has the right to take action pursuant to a consistently applied policy prohibiting substance abuse)

Serious health conditions usually would not include:

- Voluntary or cosmetic treatments
- Routine physical, eye or dental examinations
- Common cold, flu, earaches, minor ulcers, upset stomachs, headaches other than migraines, unless complications arise

ADDITIONAL COMMENTS:_____

_____

_____

_____

_____