

## Certification of Health Care Provider

Form D

Date Received by Disability and Leaves: \_\_\_\_\_

(To be sent to employee with Form A or Form C)

**Employee must provide to his or her health care provider and return within 15 calendar days of taking leave.**

1. Employee' Name \_\_\_\_\_
  
2. Patient's Name (if different from employee's) \_\_\_\_\_
  
3. The attached sheet, (attachment D, page 4) describes what is meant by a "serious health condition"<sup>1</sup> under the Family and Medical Leave Act. Does the patient's condition qualify under any of the categories described? If so, check the applicable category.  
 1     2     3     4     5     6     None of those listed
  
4. Describe the medical facts that support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:  
 \_\_\_\_\_  
 \_\_\_\_\_
  
5. (a) State the approximate date the condition commenced and the probable duration of the condition (and also the probable duration of the patient's present incapacity<sup>2</sup> if different):  
 \_\_\_\_\_  
 \_\_\_\_\_
  
- (b) Will it be necessary for the employee to work only intermittently or to work on a less-than=full schedule as a result of the condition (including for treatment described in item 6 below)?  
 Yes     No    If yes, indicate the schedule for such intermittent leave and the probable duration:  
 \_\_\_\_\_  
 \_\_\_\_\_
  
- (c) If the condition is a chronic condition (condition 4) or pregnancy, state whether the patient is currently incapacitated<sup>2</sup> and the likely duration and frequency of episodes of incapacity.<sup>2</sup>  
 \_\_\_\_\_  
 \_\_\_\_\_
  
6. (a) If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments.  
 \_\_\_\_\_  
 \_\_\_\_\_
  
- (b) If the patient will be absent from work or other daily activities because of treatment on an intermittent or part-time basis, also provide an estimate of the probable number of and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:  
 \_\_\_\_\_  
 \_\_\_\_\_

(c) If any of these treatments will be provided by another provider of health services (e.g., a physical therapist), please state the nature of the treatments.

(d) If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs or physical therapy requiring special equipment):

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7. (a) If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind?

Yes       No

(b) If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job? (the employee or the employer should supply you with information about the essential job functions.)

Yes       No      If yes, please list the essential functions the employee is unable to perform:

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(c) If neither (a) nor (b) applies, is it necessary for the employee to be absent from work for treatment?

Yes       No

8. (a) If an employee requires leave to care for the employee's family member with a serious health condition, does the patient require assistance for basic medical or personal needs, for safety, or for transportation?

Yes       No

(b) If no, would the employee's presence provide psychological comfort and be beneficial to the patient or help the patient recover?

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(c) If the patient will need care only intermittently or on a part-time basis, please indicate the schedule of the intermittent care and the probable duration of this need:

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<b>Please Print</b>			
_____		_____	
Name of Health Care Provider		Type of Practice	
_____		_____	_____
Street Address	City	State	ZIP Code
_____		_____	
Telephone Number		Date	
_____			
Signature of Health Care Provider			

<b>To be completed by the employee needing family leave to care for a family member:</b>	
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 a full schedule:	
_____	
_____	
If you are a teacher requesting reduced-schedule leave or intermittent leave, please refer to section IV.E. of the current version of Regulation 4835.	
_____	_____
Employee Signature	Date

cc: Personnel Medical File - Employee ID # \_\_\_\_\_

A “Serious Health Condition<sup>1</sup>” 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<sup>2</sup> or subsequent treatment in connection with or consequent to such inpatient care.

**2. Absence Plus Treatment**

A period of incapacity<sup>2</sup> of more than three consecutive calendar days (including any subsequent treatment or period of incapacity<sup>2</sup> relating to the same condition) that also involves one of the following:

- (a) Treatment<sup>3</sup> 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., a 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, that results in a regimen of continuing treatment<sup>4</sup> 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 requiring treatment is one that:

- (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)
- (c) May cause episodic rather than a continuing period of incapacity<sup>2</sup> (e.g., asthma, diabetes, epilepsy, etc.).

**5. Permanent or Long-Term Conditions Requiring Supervision**

A period of incapacity<sup>2</sup> that 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 there from) 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<sup>2</sup> of more than three consecutive calendar days in the absence of medical intervention of treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

<sup>1</sup>Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking family medical leave.

<sup>2</sup>“Incapacity,” for purposes of the FMLA, means inability to work, attend school, or perform other regular daily activities due to a serious health condition, the treatment therefore, or the recovery there from.

<sup>3</sup>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.

<sup>4</sup>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 taking over-the-counter medications such as aspirin, antihistamines, or salves; resting in bed; drinking fluids; exercising and/or practicing other similar activities that can be initiated without a visit to a health care provider.