FMLA DESCRIPTION OF SERIOUS HEALTH CONDITION[1]

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[2] 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; *or*

(b) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment[3] 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[4] (e.g., asthma, diabetes, epilepsy).

5. Permanent/Long-term Conditions Requiring Supervision

A period of incapacity[4] 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 incapacity[4] 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).

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1 Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

2 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.

3 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.

4 "Incapacity," for purposes of FMLA, 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.

CERTIFICATION BY EMPLOYEE'S HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS ILLNESS – FMLA

This form is to be completed by employee's Health Care Provider when employee is requesting FMLA and ***medical documentation is required*** *pursuant to 512.41, 513.36 and 515.5 of the ELM.* ***Form PS 3971 must be completed by employee.***

Employee's Name: _____

EIN: _____ **FMLA Case # (if known):** _____

Description of serious health condition (*On the back of this form is the description of "serious health condition" under FMLA. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category. In all instances the information on the form must relate only to the serious health condition for which the current need for leave exists.)*

____ **(1) Hospital Care** ____ **(3) Pregnancy** ____ **(5) Permanent/Long Term Condition**

____ **(2) Absence Plus Treatment** ____ **(4) Chronic 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 the 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):

_____

_____

_____

_____

_____

Date condition commenced: _____

Probable duration of condition: _____

Probable duration of present incapacity (if different): _____

Will the employee require leave on an intermittent or reduced schedule basis for planned medical treatment (e.g. follow-up treatment) of the employee's serious health condition, including pregnancy? _____Yes _____No

If yes, please provide an estimate of the dates and duration of such treatment and any period(s) of recovery:

Dates: _____

Duration: _____ **hour(s) or** _____ **day(s) per episode**

Period of Recovery: _____

Will the employee require leave on an intermittent or reduced schedule basis for the employee's serious health condition, including pregnancy that may result in unforeseeable episodes of incapacity (e.g. flare ups)? _____ Yes _____ No

If yes, please provide an estimate of the frequency and duration of such episodes of incapacity (e.g. 3 times per 1 month lasting 1-2 days):

Frequency: _____ **times per** _____ **week(s)** _____ **month(s)**

Duration: _____**hour(s) or** _____ **day(s) per episode**

Is the employee able to perform the essential functions of employee's position? _____ Yes _____No

If no, describe the physical restrictions placed on the employee, including the duration of such restrictions.

_____

_____

Health Care Provider's Signature:_____ **Date:** _____

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

Address: _____

Telephone Number: _____ **Fax Number:** _____

Specialty/Type of Practice: _____

(See Page 2 of this Form for Complete Description of FMLA "Serious Health Condition")

HEALTH CARE PROVIDER CERTIFICATION OF EMPLOYEE'S FAMILY MEMBER SERIOUS ILLNESS – FMLA

This form is to be completed by employee's Health Care Provider when employee is requesting FMLA and ***medical documentation is required*** *pursuant to 512.41, 513.36 and 515.5 of the ELM.* ***Form PS 3971 must be completed by employee.***

Employee's Name: _____

EIN: _____ **FMLA Case # (if known):** _____

Patient's Name: _____

Relationship to employee: ____ Spouse ____ Parent ___ Child (under age 18 or if older and incapable of self care due to a mental or physical disability)

Description of serious health condition (*On the back of this form is the description of "serious health condition" under FMLA. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category. In all instances the information on the form must relate only to the serious health condition for which the current need for leave exists.)*

____ **(1) Hospital Care** ____ **(3) Pregnancy** ____ **(5) Permanent/Long Term Condition**

____ **(2) Absence Plus Treatment** ____ **(4) Chronic 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 the 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):

_____

_____

_____

_____

_____

Date condition commenced: _____ **Probable duration of condition:** _____

Probable duration of present incapacity (if different): _____

Does the patient require assistance for basic medical, hygiene, nutritional needs, safety, or transportation? ____ **Yes** ____ **No**

If no, would the employee's presence to provide psychological comfort be beneficial to the patients' recovery? ____ **Yes** ____ **No**

Note the probable duration of the need: _____

Will the employee require leave on an intermittent or reduced schedule basis for planned medical treatment of the family member's serious health condition (e.g. follow-up treatment): ____**Yes** ____**No**

If yes, please provide an estimate of the dates and duration of such treatment and any period(s) of recovery:

Dates: _____

Duration: _____ **hour(s) or** _____ **day(s) per episode.**

Period of Recovery: _____

Will the employee require leave on an intermittent or reduced schedule basis for the family member's serious health condition that may result in unforeseeable episodes of incapacity (e.g. flare ups)? ____ **Yes** ____ **No**

If yes, please provide an estimate of the frequency and duration of such episodes of incapacity (e.g. 3 times per 1 month lasting 1-2 days):

Frequency: _____ **times per** _____ **week(s)** _____ **month(s)**

Duration: _____**hour(s) or** _____ **day(s) per episode**

If the employee requires leave on an intermittent or reduced schedule basis to care for a covered family member with a serious health condition, briefly explain why such care is medically necessary (this can include assisting in the family member's recovery).

_____

_____

Health Care Provider's Signature _____ **Date:** _____

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

Address: _____

Telephone Number: _____ **Fax Number:** _____

Specialty/Type of Practice: _____

(See Page 2 of this Form for Complete Description of "Serious Health Condition")