



Family Leave Provider Verification Form

CERTIFICATION OF HEALTH CARE PROVIDER FOR FAMILY MEMBER'S SERIOUS HEALTH CONDITION

Employee Instructions

- Use this form for **Family Health Leave**.
- You must complete, sign, and date Part I.
- Have the Health Care Provider complete and sign Part II.
- You are responsible for returning or ensuring the return of the completed form.

Part I: To be completed by the Employee

Employee Name: _____

EMPLID: _____

Title: _____

Department: _____

Telephone - Work: _____

Telephone - Home: _____

Name of Family Member: _____

Relationship: _____

If son or daughter, age: _____

State the care you will need to provide:

Your signature below indicates that you have read and understand the Medical Leaves for Staff policy and agree to the Leave provisions.

Employee Signature: _____

Date: _____

Note: Health Care Provider must complete Part II on following pages

Part II: To be completed by Health Care Provider

PART A: MEDICAL FACTS

Patient Name: _____

1. Approximate date condition commenced: _____
 - a. Probable duration of condition: _____
 - b. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
 No Yes
 - i. If yes, dates of admission: _____
 - c. Date(s) you treated the patient for condition: _____
 - d. Will the patient need to have treatment visits at least 2x per year due to the condition? No Yes
 - e. Was medication, other than over-the-counter medication, prescribed? No Yes
 - f. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? No Yes
 - i. If yes, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? No Yes
 - a. If yes, expected delivery date: _____
3. Will the patient needing care by the employee seeking leave include assistance with basic medical, hygienic, nutritional, safety, or transportation needs, or the provision of physical or psychological care? No Yes
4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? No Yes
5. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment): _____
 - a. Does the patient's condition qualify under the categories described above?
 1 2 3 4 5 None

PART B: AMOUNT OF LEAVE NEEDED

When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety, or transportation needs.

6. Will the patient be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? No Yes
 - a. If yes, estimate the beginning and ending dates for the period of incapacity: _____
 - b. Will the patient require follow-up treatments, including any time for recovery? No Yes
 - c. Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: _____

 - d. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? No Yes
 - e. Estimate the hours the patient needs care on an intermittent basis, if any:
_____ hours per day, _____ days per week;
From _____ through _____.
7. Explain the care needed by the patient, and why such care is medically necessary: _____

8. Will the condition cause episodic flare-ups periodically preventing the patient from participation in normal daily activities? No Yes
9. Based on the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months, lasting 1-2 days)
Frequency: _____ # times per week or month
For _____ # hours or days per episode.

Note: Health Care Provider must sign next page!

PART C: HEALTH CARE PROVIDER

Health Care Provider’s Name: _____

Type of practice/medical specialty: _____

Telephone: _____ Fax: _____

Signature of Health Care Provider: _____

Date: _____

Description of Serious Health Condition

825.113 SERIOUS HEALTH CONDITION.

(a) For purposes of FMLA, “serious health condition” entitling an employee to FMLA leave means an illness, injury, impairment or physical or mental condition that involves inpatient care as defined in §825.114 or continuing treatment by a health care provider as defined in §825.115. (b) The term “incapacity” means inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom. (c) The term “treatment” includes (but is not limited to) 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. 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 (e.g. , oxygen). A regimen of continuing treatment that includes 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, is not, by itself, sufficient to constitute a regimen of continuing treatment for purposes of FMLA leave.

1. § 825.114 INPATIENT CARE.

Inpatient care means an overnight stay in a hospital, hospice, or residential medical care facility, including any period of incapacity as defined in §825.113(b), or any subsequent treatment in connection with such inpatient care.

2. § 825.115 CONTINUING TREATMENT.

A serious health condition involving continuing treatment by a health care provider includes any one or more of the following:

(a) Incapacity and treatment. A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves: (1) 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 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 (2) Treatment by a health care provider on at least one occasion, which results in a regimen of continuing treatment under the supervision of the health care provider. (3) The requirement in paragraphs (a)(1) and (2) of this section for treatment by a health care provider means an in-person visit to a health care provider. The first (or only) in-person treatment visit must take place within seven days of the first day of incapacity. (4) Whether additional treatment visits or a regimen of continuing treatment is necessary within the 30-day period shall be determined by the health care provider.

3. (b) Pregnancy or prenatal care. Any period of incapacity due to pregnancy, or for prenatal care.

4. (c) Chronic conditions. Any period of incapacity or treatment for such incapacity due to a chronic serious health condition. A chronic serious health condition is one which: (1) Requires periodic visits (defined as at least twice a year) for treatment by a health care provider, or by a nurse under direct supervision of a health care provider (2) Continues over an extended period of time (including recurring episodes of a single underlying condition); and (3) May cause episodic rather than a continuing period of incapacity (e.g. , asthma, diabetes, epilepsy, etc.).

5. (d) Permanent or long-term conditions. A period of incapacity 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.

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA) FMLA CERTIFICATION DISCLOSURE

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. ‘Genetic information,’ as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. Please return this signed form to Human Resources with the completed “Certification of Health Care Provider” Form.