Sample Form #2A

FMLA

Medical Certification Statement
(Employee's Own Serious Illness)

Employee's name:____

Date condition began:____

Date condition ended (or is expected to end):____

Medical facts regarding the condition:____

____

____

____

____

Explanation of extent to which employee is unable to perform the functions of his or her job:

____

____

____

____

Health care provider signature:____Date:_______________

Office phone: ____

- -

Medical Release:

I authorize the release of any medical information necessary to process the above request.

Employee/Patient's signature: ______________________________________Date:_______________

© HRA, All rights reserved

Sample Form #2B

FMLA

Medical Certification Statement
(For Employee's Family)

1. Employee's name:____

2. Patient's name (if different from employee): ______________________________

3. The attached sheet describes what is meant by a "serious health condition" under the Family and Medical Leave Act (FMLA). Does the patient's condition[1] qualify under any of the categories described? If so, please check the applicable category:

   (1) ____ (2) ____ (3) ____ (4) ____ (5) ____ (6) ____, or None of the above ______

4. Describe or attavh the medical facts which 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,[2] if different):

b. Will it be necessary for the employee to take 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)?_________

If yes, give the probable duration:____________________________________

c. If the condition is a chronic condition (condition #4) or pregnancy, state whether the patient is presently incapacitated[2] and the likely duration and frequency of episodes of incapacity[2]:

____

6 a. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments.

____

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 and interval between suchtreatments, actual or estimated dates of treatment if known, and period required for recovery, if any:

____

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

____

____

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

[2] "Incapacity," for FMLA purposes, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.

Form WH-380
December 1994

© HRA, All rights reserved

Sample Form #2B (cont'd.)

c. 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, physical therapy requiring special equipment):

____

____

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? _______________

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)? ______ If yes, please list the essential functions the employee is unable to perform:

____

____

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

8. a. If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation?

____

b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? _________

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

____

____

Signature of health care provider:____Date:______________

Type of practice:____

Address:____

Telephone number:____

- — -

The section below to be completed by the employee requesting family leave 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 a full schedule:

____

____

Employee's signature:____Date:_______________

© HRA, All rights reserved

Sample Form #2B (Attachment.)

The interpretation of a serious health condition:

1) Any illness, injury, impairment, or physical or mental condition that involves in-patient care or continuing treatment by a health care provider. Health care provider generally means one that would be acceptable by your health care plan for a medical certification of the related illness. With the exception of a registered Christian Science practitioner, the provider must be licensed to practice in the state.) This includes any illness, injury, impairment or physical or mental condition that involves an overnight hospital stay or continuing treatment.

"Continuing treatment" means treatment for:

2) An incapacity of more than three consecutive days involving two or more treatments or a supervised schedule of continuing treatments.
3) An incapacity due to pregnancy including morning sickness or prenatal care.
4) An incapacity due to a chronic health condition (such as asthma, diabetes, or epilepsy).
5) An incapacity that is permanent or long term (such as severe stroke or terminal cancer).
6) Any condition that if not treated would likely result in an incapacity of more than three days (such as kidney dialysis or chemotherapy or drug rehabilitation).

Items not covered under a serious health condition include:

- Common cold
- Flu
- Ear aches
- Upset stomach
- Minor ulcers
- Headaches (other than migraine)
- Routine dental
- Periodontal disease
- Allergies*
- Mental illness resulting from stress*
- Cosmetic treatments*
- Alcoholism*
- Drug abuse*

**Asterisked items may be covered as a serious health condition if they also meet the requirements listed above as continuing treatment, but not for any independent occurrence. Absences due to substance abuse are not covered under FMLA unless the leave is for a medically supervised rehabilitation or treatment.*

© HRA, All rights reserved