NALC Form 1 - Family and Medical Leave Act

Health Care Provider: Please complete this form in order to aid the employer in making its FMLA determination.

Medical Certification—Employee's Own Serious Health Condition

The employee's health care provider must complete this form when an employee requests FMLA leave and medical documentation is required (see ELM Sections 512.41, 513.36 and 515.5). The employee must also complete and submit a PS Form 3971 - Request for or Notification of Absence.

Employee: Return the completed form to the appropriate FMLA administration HRSSC address or fax (see attached sheet) and keep a copy for your own records.

Employee's Name: _____

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

1. Medical facts: The back (p. 2) of this form contains sets of medical facts that the FMLA uses to define a serious health condition. Does the employee's health condition[1] match any of these sets of medical facts? If so, please check the applicable set.

❒ 1. Hospitalization ❒ 2. Absence plus Treatment ❒ 3. Pregnancy ❒ 4. Chronic Condition ❒ 5. Permanent/Long-term ❒ 6. Multiple Treatments ❒ None of these

2. Description of medical facts: Please describe the medical facts that correspond to the set of medical facts checked above. Such medical facts may include symptoms, hospitalization, doctor visits, whether medicine has been prescribed and any regimen of continuing treatment. A specific diagnosis or prognosis is not required.

_____

3. Duration of the condition (Be as specific as you can; terms such as "lifetime," "unknown" or "indeterminate" should be used only when they reflect your best medical judgment.)

a. Approximate date condition commenced: _____ Probable duration of condition: _____

4. Is the employee able to perform the essential functions of his or her position? ❒ Yes ❒ No

If no, please describe the employee's restrictions and their duration:

_____

5. Will the employee require leave that is medically necessary on an intermittent or reduced schedule basis for planned medical 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(s) and any period(s) of recovery.

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

Period of Recovery: _____

Estimate the part-time or reduced work schedule the employee needs, if any:

_____ hour(s) per day; _____ day(s) per week from _____ through _____.

6. Will the employee require leave that is medically necessary on an intermittent or reduced schedule basis for the employee's serious health condition, including pregnancy, that may result in unforeseeable episodes of incapacity[2] (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 episodes every 2 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s) **Duration:** _____ hours or _____ day(s) per episode

_____

Health Care Provider Signature: _____ Date:_____

Print Name: _____ _____ Phone: (_____)_____

Medical Practice/Specialty: _____ FAX: _____

Address: _____

_____

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

[2] Flare-ups or other unforeseeable leave in the case of chronic conditions or pregnancy need not require treatment by a health care provider.

"Serious Health Condition"

Definition under the Revised Family and Medical Leave Act

A "serious health condition" of a family member is defined in the FMLA regulations as any illness, injury, impairment or physical or mental condition that involves one of the following:

1. Hospital care:

This means inpatient care (that is, an overnight stay) in a hospital, hospice or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence plus treatment:

A period of incapacity[3] of **more than three full consecutive calendar days** (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

a. Treatment[4] two or more times[5] 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

b. Treatment (in person visit) by a health care provider on **at least one occasion[6]** which results in **a regimen of continuing treatment[7]** 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 which

a. Requires **periodic visits[8]** for treatment by a health care provider, or by a nurse 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 (e.g., asthma, diabetes, epilepsy).

5. Permanent/long-term conditions requiring supervision:

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.

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 of **more than three consecutive calendar days in the absence of medical intervention or treatment** such as cancer (chemotherapy, radiation, etc), severe arthritis (physical therapy), kidney disease (dialysis).

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

[4] **"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.

[5] **"Two or more times"** must be within 30 days of beginning period of incapacity and the first visit must be within 7 days of the first day of incapacity.

[6] **"one occasion"** must be within 7 days of the first day of incapacity.

[7] 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 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.

[8] **"Periodic visits"** must include at least 2 visits a year.

Family and Medical Leave Act (FMLA) Administration
Human Resources Share Service Center (HRSSC)
Contact Information

1-877-477-3273 Option 5, then Select 6
TTY: 1-866-833-8777

HRSSC FMLA 10 Employees

FMLA SPECIALIST
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