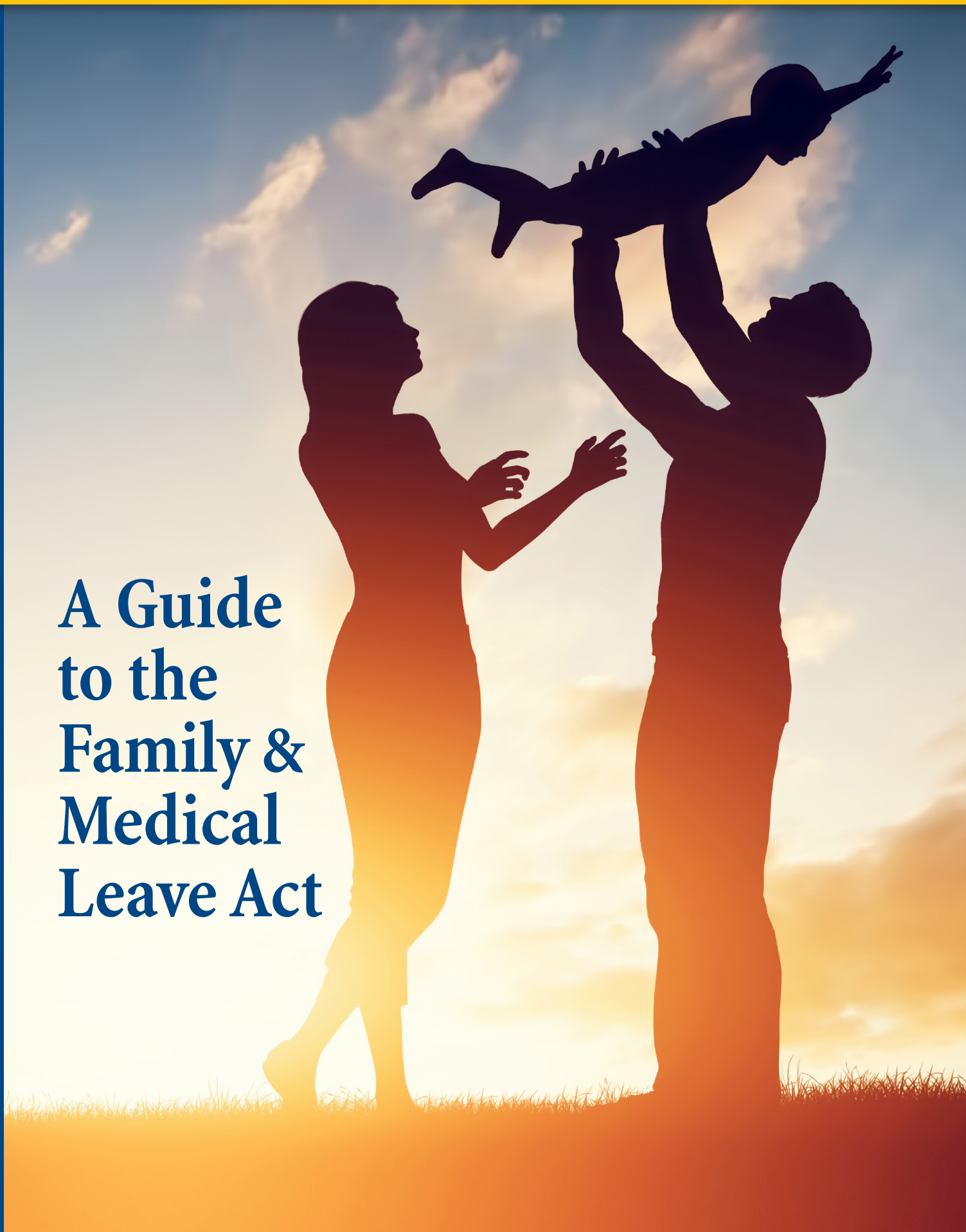
APWU American Postal Workers Union, AFL-CIO



A Guide to the Family & Medical Leave Act

This guide was prepared by the
Industrial Relations Department,
Tony D. McKinnon, Sr., Director.

June 2016

Dear APWU Sisters and Brothers,

The Family and Medical Leave Act (FMLA) provides significant job protection to postal workers when time off is needed to attend to serious medical issues and certain family events. It was a significant step forward in creating a better balance between work and our personal lives.

Since the inception of the law, the APWU has ensured that you, the member, are familiar with your rights.

This new booklet, prepared by the APWU Industrial Relations Department, continues this ongoing effort. It contains important updates and new information regarding the FMLA.

I am confident you will find this information valuable and hope you avail yourselves of your rights under this important legislation.

Yours in Union Solidarity,

Mark Dimondstein
President

A Guide to the Family & Medical Leave Act

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A GUIDE TO THE FAMILY & MEDICAL LEAVE ACT

UNDER THE FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA), eligible employees of the U.S. Postal Service are entitled to receive unpaid leave for qualified medical and family reasons. Qualified medical and family reasons include: personal or family illness, pregnancy, adoption, or the foster-care placement of a child.

The FMLA is intended "to balance the demands of the workplace with the needs of families." It allows eligible employees to take up to 12 work weeks of unpaid leave during any 12-month period to attend to the serious health condition of the employee, his or her parent, spouse or child, or for pregnancy or care of a newborn child, or for adoption or foster care of a child.

To be eligible for FMLA leave, an employee must have been employed by the employer at least 12 months, and worked at least 1,250 hours over the past 12 months, and work at a location where the employer employs 50 or more employees within 75 miles.

The National Defense Authorization Act for FY 2008 amended the FMLA to provide two types of military family leave for FMLA-eligible employees: "qualifying exigency leave" and "military caregiver leave."

The FMLA is administered by the Wage and Hour Division of the U.S. Department of Labor. The Postal Service is required to abide by the FMLA, and has incorporated its requirements into the Employee and Labor Relations Manual (ELM). The Collective Bargaining Agreement (CBA) between the APWU and the USPS incorporates many of the FMLA's protections as well.

This booklet is designed to explain union members' rights and obligations for requesting leave under the FMLA, the ELM and the CBA. For more information, please contact your local representative.

Who Can Use FMLA Leave?

Employees who meet the following requirements are eligible for FMLA leave:

- Worked for the USPS for at least 12 months before the leave is taken ***and***
- Worked at least 1250 hours in the 12-month period before the leave is taken.

The same eligibility requirements apply to employees seeking qualifying exigency leave and/or military caregiver leave.

How Much Leave Can Be Taken?

Employees may use up to 12 workweeks in any leave year for FMLA or qualifying exigency leave. Together, FMLA leave and qualifying exigency leave may total no more than 12 workweeks in any leave year.

USPS tracks this by hours, based on 12 weeks times the hours normally/regularly scheduled in the employee's workweek.

- Employees who work 40 hours/week, may use 480 hours of FMLA leave per leave year.
- Employees who work 30 hours/week, may use 360 hours of FMLA leave per leave year.

A "leave year" begins on the first day of the first complete pay period in a calendar year and ends on the day before the first day of the first complete pay period in the following calendar year.

Employees may use up to 26 workweeks in a single 12-month period for military caregiver leave.

A "single 12-month period" begins with the first day of leave; it is not the same as a "leave year."

Military caregiver leave may be combined with FMLA leave up to a maximum of 26 workweeks of leave in a single 12-month period.

Example: An employee who uses 22 workweeks of military caregiver leave from June to November will only be able to use 4 workweeks of FMLA leave from November to June of the next year. This is the case even though it means the employee is not using 12 workweeks of FMLA leave within the leave year.

- If the leave qualifies for both military caregiver leave and FMLA leave, the USPS must designate it as military caregiver leave first.
- If the leave qualifies for both, the USPS cannot count it against both the 26-week military caregiver leave and the 12-week FMLA leave for other FMLA-qualifying reasons, except that, as explained above, a maximum of 26 workweeks of combined leave may be taken in any 12-month period.

How Can Leave Be Taken?

- The leave can be taken in a single block of time.
  Example: One month to recover from surgery
- The leave can be taken in multiple, smaller blocks of time if medically necessary. (This is known as "intermittent leave.")
  Example: Occasional absences due to condition or for doctor appointments.

- The leave can be taken on a part-time basis if medically necessary.
  Example: After surgery an employee can only return to work for 4 hours per shift or 3 shifts per week for a period of time.
- Employees must schedule intermittent leave at a time that minimizes the disruption to the employer, where possible.
- Unused leave cannot be carried over into the next leave period or 12-month period.
- Generally, FMLA leave is unpaid unless employees use accrued sick or vacation leave at the same time.
  - Employees may use up to 80 hours of sick leave to care for son, daughter, parent or spouse. This would run concurrently with – not consecutive to – FMLA leave; that is, employees would max out at 12 weeks, not 12 weeks plus 80 hours.
  - USPS cannot require employees to exhaust annual and sick leave before they request unpaid leave.

When Can FMLA Leave Be Taken?

- For the birth of a child or placement of a child with the employee through adoption or foster care.
  - Applies to both mother and father.
  - Must be taken within 1 year of a child's birth or placement.
  - Must be taken in 1 block unless the employer agrees to schedule intermittent leave.
- For a serious health condition of yourself or your spouse, child or parent.
  - "Spouse" is husband or wife, and includes legally-married same-sex spouses (as long as the marriage was legal in the state it was celebrated, even if the couple live in a state that does not recognize same-sex marriage).
  - "Child" includes biological, adopted, foster and stepchildren, as well as legal wards and a child of a person standing *in locos parentis* (a person who has day-to-day responsibility to care for and financially support the child);

if the child is over 18, he or she must be incapable of self-care because of a mental or physical disability at time the leave begins.

- "Parent" includes biological, adopted, foster and step-parents, as well as persons who stood *in loco parentis* to the employee when the employee was a child, but not in-laws.

- To care for an ill or injured spouse, son, daughter, parent or next of kin who is a covered service-member. *(See below.)*

  - For a qualifying exigency arising from the foreign deployment of an employee's spouse, son, daughter, or parent who is a member of the Armed Forces (including the National Guard and Reserves). (*See below*.)

What Constitutes a 'Serious Health Condition?'

"Serious health condition" means illness, injury, impairment, or physical or mental condition that involves any of the following:

- Pregnancy (includes prenatal medical appointments, incapacity due to morning sickness, and medically-required bed rest). If the employee is unable to report to work because of morning sickness, the leave can be covered even though she is not treated by doctor during absence.

- Overnight stay in a hospital or other medical care facility.

- Incapacity (unable to work or attend school) for more than 3 consecutive days ***AND***

  - Two or more treatments by health care provider within 30 days of first day of incapacity ***OR***

  - One treatment by health care provider and follow-up care such as prescription medication.

  - First (or only) treatment must be within 7 days of the first day of incapacity. *Example:* The flu or bronchitis won't qualify unless a doctor certifies the employee must be out of work more than 3 days and writes a prescription.

- Chronic condition that requires treatment at least twice a year, continues over extended period of time, and causes occasional periods of incapacitation. Employees who are unable to report to work because of a chronic condition may be covered even if they are not treated by a doctor during their absence.

  Example: Diabetes

- Period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective; person must be under continuing supervision of health care provider, but not necessarily under active treatment.

  Example: Stroke, Alzheimer's

- Period of absence to receive multiple treatments (and period of recovery afterward) for restorative surgery after an accident or injury or for a condition that would likely result in incapacity of more than 3 consecutive days if not treated.

  Example: Cancer, kidney disease

What Constitutes a 'Qualifying Exigency?'

A "qualifying exigency" arising out of foreign deployment may include:

- Issues arising from the military member's deployment with seven or fewer days of notice.
- Making or updating financial and legal arrangements to address a military member's absence.
- Attending counseling by non-healthcare providers for the employee, the military member, or a child of the military member that is needed due to the active duty or the call to active duty.
- Attending military ceremonies, programs or informational briefings related to the military member's active duty.
- Spending up to 15 calendar days with a military member who is on rest and recuperation leave.
- Certain childcare and related activities for the military member's child while the military member is on active duty.

- Attending post-deployment activities within 90 days of the end of the military member's active duty or to attend to issues arising from the death of a military member while on active duty.
- Certain parental care activities for the military member's parent who is incapable of self-care.
- Any other event that the employee and the USPS agree is a qualifying exigency; both the employee and the USPS must agree to the timing and duration of the leave.

Caring for a Covered Servicemember

Military caregiver leave may be taken to care for an ill or injured spouse, son, daughter, parent or next of kin who is a covered servicemember.

A "covered servicemember" is a current member of the Regular Armed Services, National Guard or Reserves who is:

- Undergoing medical treatment, recuperation or therapy;
- Is otherwise in outpatient status;
- Is otherwise on the temporary disability retired list,

And

- Incurred a serious injury or illness while in the line of duty on active duty. "Serious injury or illness" in this case means an injury or illness that renders the servicemember unfit to perform the duties of the member's office, grade, rank or rating.

"Next of kin" is the covered servicemember's nearest blood relative, other than the spouse, parent, son or daughter, in the following order: first, a relative designated in writing; if none, a blood relative with legal custody; if none, a brother or sister; if none, a grandparent; if none, an aunt or uncle; if none, a first cousin.

Employees may use leave for more than one covered servicemember ***or*** to care for more than one injury for the same covered servicemember, as long as a maximum of 26 workweeks of military caregiver leave is taken in a single 12-month period.

Example: Employees may use 20 workweeks to care for an eligible son, and then 6 workweeks to care for an eligible spouse in the same 12-month period.

Example: Employees may use 16 workweeks to care for an eligible son with a leg injury, and then 10 workweeks to care for the eligible son who incurs a head injury in the same 12-month period.

Job Protection for FMLA Leave

- The USPS may assign employees who used intermittent leave or reduced work schedules different duties temporarily, in conformity with the CBA, but must pay them same wages and benefits as before.
- The USPS must return employees to same job (or one nearly identical to it) at the end of their leave.
- The USPS must continue health insurance coverage while employees are on leave (but can required them to pay any normal employee contributions).
- The USPS cannot penalize employees for taking FMLA leave when making hiring, discipline or promotion decisions.

Procedure for Requesting FMLA Leave

- Employees must give the USPS notice
    - 30 days' advance notice if you know you will need time in advance (pregnancy, surgery, etc.).
    - If you can't give 30 days' notice, you must give as much notice as soon as possible.
      Example: The day you learn you need the leave or the next work day.
      Example: In emergency situations, as soon as you can.
      The requirement to provide as much advance notice as possible applies to qualifying exigency leave as well.
- If the need for leave is unforeseeable, you must use the usual notice and call-in procedures unless you are unable to do so.

What Documentation is Required?

- For qualifying exigency leave, the USPS has the right to require documentation of the need for leave.
  Example: Active duty orders; documentation of rest and recuperation period, counseling or child care appointments, or bills for services for handling legal or financial affairs.
- For FMLA leave, the USPS has the right to require certification of the medical condition.
    - Employees must provide enough information so that the USPS can tell the leave may be covered by the FMLA.
    - The ELM requires employees to submit Form 3971 and the medical provider to submit a form.
    - Employees and their doctors are not required to complete any specific form BUT, per the ELM, the USPS automatically sends employees DOL forms in certain situations, such as emergency leave.
      APWU forms are provided at the back of this booklet and at *www.apwu.org*.

- You do not have to tell USPS your diagnosis, but you must provide information indicating that leave is required for an FMLA-protected condition.
  Example: Doctors do not have to say on the certification form that the employee has a sinus infection; a doctor need only say that she has prescribed antibiotics and told the employee to stay home for 4 days.
  See the APWU sample forms at the back of this booklet and at www.apwu.org.

- The USPS may require you to correct deficiencies in the certification; you have 7 days to do so (unless it is not practicable to do so using good faith and diligence).

Management's Response to FMLA Leave Requests

- The USPS must notify you within 5 business days of your request for leave whether it is approved.
- The notification must include a notice of your rights and responsibilities under the FMLA.
- The same notice and certification requirements apply to military caregiver leave.
- The USPS may require a second opinion from its own doctor (and a third if the two disagree).
  - This does ***not*** apply to qualifying exigency leave or military caregiver leave when the servicemember is treated by DOD, VA or Tricare providers – in these situations the USPS cannot require a second opinion.
- The USPS may require recertification of leave.
  - This does ***not*** apply to qualifying exigency leave or military caregiver leave when the servicemember is treated by DOD, VA or Tricare providers—in these situations the USPS cannot require recertification.
- For FMLA Leave, the USPS cannot require recertification more frequently than every 30 days. Additionally, recertification has to at minimum match the duration of the condition in the original certification.
  Example: If an employee is out of work for six

weeks for surgery, the USPS cannot request recertification within the six-week leave period.

- Exceptions:
  - The employee requests to extend his or her leave.
  - There is a change in the duration or frequency of absences or in the nature or severity of the illness.

    Example: An employee requested intermittent leave for migraines lasting 1-2 days, but the employee's absences last 3-4 days.

    Example: There is a suspicious pattern of the employee taking unscheduled FMLA intermittent leave adjacent to scheduled days off.
  - The USPS receives information that casts doubt on the stated reason for requested leave or the continued validity of the certification.

    Example: The employee is out of work for knee surgery but is seen playing softball during his or her leave.
- The USPS must give employees 15 calendar days' notice to produce recertification, and employees must do so unless it is not practicable under the particular circumstances despite good faith and diligence.
- The USPS may require recertification every six months in connection with certain absences.

  Example: If the original certification says an employee has a chronic condition requiring intermittent leave or a reduced work schedule for more than six months, the USPS may request recertification every six months in connection with an absence.
- If a serious health condition lasts beyond a single leave year, the USPS may request recertification in subsequent leave years.

Returning from Leave

- To return to work after your own incapacitation, you must provide certification from your doctor that you are able to perform essential functions of the job.
- The USPS must return you in same position or an equivalent position.
  - Equivalent pay, benefits, working conditions, such as schedule and location.
  - Employees have no right to benefits or positions they would not have been entitled to absent the leave.

CERTIFICATION OF EMPLOYEE'S SERIOUS HEALTH CONDITION FOR FAMILY AND MEDICAL LEAVE

This form must be completed by a Health Care Provider when FMLA leave is requested and medical documentation is required pursuant to 512.41, 513.36 and 515.5 of ELM. **In all instances the information on the form must relate only to the serious health condition for which the current need for leave exists.** ***Form PS 3971 also must be completed by employee and submitted to properly request FMLA leave.*** *PLEASE REVIEW THE COMPLETE FORM AND COMPLETE ALL SECTIONS THAT APPLY. FAILURE TO PROVIDE COMPLETE INFORMATION COULD RESULT IN DELAY OR DENIAL OF LEAVE REQUEST.*

I. EMPLOYEE INFORMATION

Employee's Name: _____

EIN: _____ FMLA Case # _____

II. CONDITION REQUIRING LEAVE

Please check the box below for the type of serious health condition the Employee has. ***See page 3 for a complete description of what constitutes a "serious health condition" for purposes of the FMLA.***

__ 1. **Hospital Care**
__ 2. **Absence Plus Treatment**
__ 3. **Pregnancy**
__ 4. **Chronic Condition**
__ 5. **Permanent Long-term 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 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***. **Note For Chiropractors**: Under the FMLA, a serious health condition involving chiropractic treatment is limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist. No X-rays are needed, but a statement that a subluxation was identified by X-rays should be provided.

_____

_____

_____

_____

III. DURATION AND EXTENT OF LEAVE REQUIRED

What is the date the condition commenced? _____

On which dates did you treat the Employee in the past 12 months? _____

How long do you project the condition to continue? _____

How long will the Employee be incapacitated (if different)? _____

How long will the Employee need to be on leave because of the condition? _____

_____

Will the Employee need treatment at least twice per year for the condition? ___ Yes ___ No

Will the Employee require intermittent leave or a reduced work schedule due either to planned medical treatment (for example, follow-up visits or physical therapy), or because of unforeseeable episodes of incapacity (for example, flare ups of symptoms)? ___Yes ___ No

If yes, please provide the following additional information:

Estimated dates of scheduled treatment: _____

Frequency of treatment/episodes of incapacity: ___ times per ___week ___ month

Duration of treatment/episode of incapacity: ____hour(s) or ____ day(s)
(for example, 3 times per 1 month lasting 1-2 days per episode)

Period of Recovery: _____

Is the Employee able to perform the essential functions of the Employee's position without physical restrictions, accommodations or modification of job duties? ___ Yes ___No

If no, can the Employee perform the essential functions of the job with physical restrictions, accommodations or modifications of job duties? ___ Yes ___No

If yes, describe the physical restrictions, accommodations or modification of job duties required: _____

_____

_____

IV. HEALTH CARE PROVIDER SIGNATURE

Signature: _____ Date: _____

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

Address: _____

Telephone Number: _____Fax Number: _____

Specialty/Type of Practice: _____

FMLA DESCRIPTION OF SERIOUS HEALTH CONDITION

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 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,
(b) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment 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 (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 incapacity4 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).

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.
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.
"Incapacity," for purposes of FMLA, Incapacity 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.

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CERTIFICATION OF FAMILY MEMBER'S SERIOUS HEALTH CONDITION FOR FAMILY AND MEDICAL LEAVE

This form must be completed by a health care provider when FMLA leave is requested and medical documentation is required pursuant to 512.41, 513.36 and 515.5 of ELM. **In all instances the information on the form must relate only to the serious health condition for which the current need for leave exists.** ***Form PS 3971 also must be completed by employee and submitted to properly request FMLA leave.*** *PLEASE REVIEW THE COMPLETE FORM AND COMPLETE ALL SECTIONS THAT APPLY. FAILURE TO PROVIDE COMPLETE INFORMATION COULD RESULT IN DELAY OR DENIAL OF LEAVE REQUEST.*

I. EMPLOYEE INFORMATION

Employee's Name: _____

EIN: _____ FMLA Case # _____

Name of Patient: _____

Relationship of Employee to patient for whom leave is requested: _____
(Spouse, Parent, Child; child over 18 must be incapable of self-care because of disability)

II. CONDITION REQUIRING LEAVE

Please check the box below for the type of serious health condition the patient has. ***See page 3 for a complete description of what constitutes a "serious health condition" for purposes of the FMLA.***

__ 1. **Hospital Care**
__ 2. **Absence Plus Treatment**
__ 3. **Pregnancy**
__ 4. **Chronic Condition**
__ 5. **Permanent Long-term 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 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***. **Note For Chiropractors**: Under the FMLA, a serious health condition involving chiropractic treatment is limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist. No X-rays are needed, but a statement that a subluxation was identified by X-rays should be provided.

_____

_____

_____

_____

III. DURATION AND EXTENT OF LEAVE REQUIRED

What is the date the condition commenced? _____

On which dates did you treat the patient in the past 12 months? _____

How long do you project the condition to continue? _____

How long will the patient be incapacitated (if different)? _____

Does the patient require assistance to meet basic medical, hygiene, nutritional, safety or transportation needs because of the condition or during periods of incapacity? ___Yes ___ No

If not, would the Employee's presence provide psychological comfort beneficial to the patient's recovery? ___Yes ___ No

How long will the Employee need to be on leave to care for the patient? _____

_____

Will the patient need treatment at least twice per year for the condition? ___ Yes ___ No

Will the Employee require intermittent leave or a reduced work schedule due either to planned medical treatment of the patient (for example, follow-up visits or physical therapy), or because of unforeseeable episodes of the patient's incapacity (for example, flare ups)? ___Yes ___ No

If yes, please provide the following additional information:

Estimated dates of scheduled treatment: _____

Frequency of treatment/episodes of incapacity: ___ times per ___week ___ month

Duration of treatment/episode of incapacity: ____hour(s) or ____ day(s)
(for example, 3 times per 1 month lasting 1-2 days per episode)

Period of Recovery: _____

IV. HEALTH CARE PROVIDER SIGNATURE

Signature: _____ Date: _____

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

Address: _____

Telephone Number: _____Fax Number: _____

Specialty/Type of Practice: _____

FMLA DESCRIPTION OF SERIOUS HEALTH CONDITION

A "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. Hospital Care
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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,
(b) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment 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 (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 incapacity4 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).

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.
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.
"Incapacity," for purposes of FMLA, Incapacity 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.

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SAMPLE FORM EMPLOYEE ABSENCE PLUS TREATMENT

CERTIFICATION OF EMPLOYEE'S SERIOUS HEALTH CONDITION FOR FAMILY AND MEDICAL LEAVE

This form must be completed by a Health Care Provider when FMLA leave is requested and medical documentation is required pursuant to 512.41, 513.36 and 515.5 of ELM. **In all instances the information on the form must relate only to the serious health condition for which the current need for leave exists.** ***Form PS 3971 also must be completed by employee and submitted to properly request FMLA leave.*** *PLEASE REVIEW THE COMPLETE FORM AND COMPLETE ALL SECTIONS THAT APPLY. FAILURE TO PROVIDE COMPLETE INFORMATION COULD RESULT IN DELAY OR DENIAL OF LEAVE REQUEST.*

I. EMPLOYEE INFORMATION

Employee's Name: Your Name Here_____

EIN: _____ FMLA Case # _____

II. CONDITION REQUIRING LEAVE

Please check the box below for the type of serious health condition the Employee has. ***See page 3 for a complete description of what constitutes a "serious health condition" for purposes of the FMLA.***

__ 1. **Hospital Care**
__ 3. **Pregnancy**
__ 5. **Permanent Long-term Condition**
X_ 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 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***. **Note For Chiropractors**: Under the FMLA, a serious health condition involving chiropractic treatment is limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist. No X-rays are needed, but a statement that a subluxation was identified by X-rays should be provided.

Patient suffers from kidney failure that incapacitates the employee during dialysis treatments and subsequent side effects such as headaches and fatigue

III. DURATION AND EXTENT OF LEAVE REQUIRED

What is the date the condition commenced? January 2015__

On which dates did you treat the Employee in the past 12 months? 1/5/2015, 1/15/2015, 2/1/2015

How long do you project the condition to continue? Lifetime to be reviewed annually

How long will the Employee be incapacitated (if different)? 4 weeks

How long will the Employee need to be on leave because of the condition? 3 times per week lasting up to 3 days per episode for 12 months

Will the Employee need treatment at least twice per year for the condition? _X_ Yes ___ No

Will the Employee require intermittent leave or a reduced work schedule due either to planned medical treatment (for example, follow-up visits or physical therapy), or because of unforeseeable episodes of incapacity (for example, flare ups of symptoms)? _X_ Yes ___ No

If yes, please provide the following additional information:

Estimated dates of scheduled treatment: 3 times a week from 1/5/15 to 7/15/13

Frequency of treatment/episodes of incapacity: _3_ times per _1_ week ___ month

Duration of treatment/episode of incapacity: ____hour(s) or _1-2_ day(s)
(for example, 3 times per 1 month lasting 1-2 days per episode)

Period of Recovery: ____1 to 3 days during dialysis treatment

Is the Employee able to perform the essential functions of the Employee's position without physical restrictions, accommodations or modification of job duties? _X_ Yes ___No

If no, can the Employee perform the essential functions of the job with physical restrictions, accommodations or modifications of job duties? ___ Yes ___No

If yes, describe the physical restrictions, accommodations or modification of job duties required: _____

IV. HEALTH CARE PROVIDER SIGNATURE

Signature: _*Dr. Charlie Cox*_____
Date:_____2/7/2015_____

Health Care Provider's Name (Please print): _____Dr. Charlie Cox_____

Address: _67 Palm Ct West Palm Beach_____

Telephone Number: _____Fax Number: _____

Specialty/Type of Practice: ____Nephrology_____

SAMPLE FORM EMPLOYEE CANCER

CERTIFICATION OF EMPLOYEE'S SERIOUS HEALTH CONDITION FOR FAMILY AND MEDICAL LEAVE

This form must be completed by a Health Care Provider when FMLA leave is requested and medical documentation is required pursuant to 512.41, 513.36 and 515.5 of ELM. **In all instances the information on the form must relate only to the serious health condition for which the current need for leave exists.** ***Form PS 3971 also must be completed by employee and submitted to properly request FMLA leave.*** *PLEASE REVIEW THE COMPLETE FORM AND COMPLETE ALL SECTIONS THAT APPLY. FAILURE TO PROVIDE COMPLETE INFORMATION COULD RESULT IN DELAY OR DENIAL OF LEAVE REQUEST.*

I. EMPLOYEE INFORMATION

Employee's Name: Your Name Here

EIN: _____ FMLA Case # _____

II. CONDITION REQUIRING LEAVE

Please check the box below for the type of serious health condition the Employee has. ***See page 3 for a complete description of what constitutes a "serious health condition" for purposes of the FMLA.***

__ 1. **Hospital Care**
__ 2. **Absence Plus Treatment**
__ 3. **Pregnancy**
__ 4. **Chronic Condition**
__ 5. **Permanent Long-term Condition**
X_ 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 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.*** **Note For Chiropractors**: Under the FMLA, a serious health condition involving chiropractic treatment is limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist. No X-rays are needed, but a statement that a subluxation was identified by X-rays should be provided.

__Patient suffers from cancer and as regimen of treatment is undergoing Chemo treatment that incapacitates the employee due to side-effects, including but not limited to nausea, pain, vomiting, and fatigue. _____

_____

III. DURATION AND EXTENT OF LEAVE REQUIRED

What is the date the condition commenced? May 3, 2015__

On which dates did you treat the Employee in the past 12 months? 5/3/15, 5/20/2015

How long do you project the condition to continue? Lifetime to be reviewed annually

How long will the Employee be incapacitated (if different)? 3 months

How long will the Employee need to be on leave because of the condition?

Intermittently 6 months to 1 year

Will the Employee need treatment at least twice per year for the condition? _X_ Yes ___ No

Will the Employee require intermittent leave or a reduced work schedule due either to planned medical treatment (for example, follow-up visits or physical therapy), or because of unforeseeable episodes of incapacity (for example, flare ups of symptoms)? _X_ Yes ___ No

If yes, please provide the following additional information:

Estimated dates of scheduled treatment: _8 cycles lasting 2 weeks in next 6 months beginning on May 20, 2015

Frequency of treatment/episodes of incapacity: 2 times per ___week _1_ month

Duration of treatment/episode of incapacity: ____hour(s) or _10_ day(s)
(for example, 3 times per 1 month lasting 1-2 days per episode)

Period of Recovery: ___3 to 8 months

Is the Employee able to perform the essential functions of the Employee's position without physical restrictions, accommodations or modification of job duties? __ Yes _X_No

If no, can the Employee perform the essential functions of the job with physical restrictions, accommodations or modifications of job duties? _X Yes ___No

If yes, describe the physical restrictions, accommodations or modification of job duties required: ____Additional breaks as needed , light duty requested.

IV. HEALTH CARE PROVIDER SIGNATURE

Signature: *Dr. Abby Moore* Date: 5/20/2015

Health Care Provider's Name (Please print): _Dr. Abby Moore

Address: _457 Union Ave, Riverhead NY

Telephone Number: Fax Number:

Specialty/Type of Practice: Oncologist

SAMPLE FORM EMPLOYEE HOSPITAL STAY

CERTIFICATION OF EMPLOYEE'S SERIOUS HEALTH CONDITION FOR FAMILY AND MEDICAL LEAVE

This form must be completed by a Health Care Provider when FMLA leave is requested and medical documentation is required pursuant to 512.41, 513.36 and 515.5 of ELM. **In all instances the information on the form must relate only to the serious health condition for which the current need for leave exists.** ***Form PS 3971 also must be completed by employee and submitted to properly request FMLA leave.*** *PLEASE REVIEW THE COMPLETE FORM AND COMPLETE ALL SECTIONS THAT APPLY. FAILURE TO PROVIDE COMPLETE INFORMATION COULD RESULT IN DELAY OR DENIAL OF LEAVE REQUEST.*

I. EMPLOYEE INFORMATION

Employee's Name: Your Name Here

EIN: _____ FMLA Case # _____

II. CONDITION REQUIRING LEAVE

Please check the box below for the type of serious health condition the Employee has. ***See page 3 for a complete description of what constitutes a "serious health condition" for purposes of the FMLA.***

_X_ 1. **Hospital Care**
__ 2. **Absence Plus Treatment**
__ 3. **Pregnancy**
__ 4. **Chronic Condition**
__ 5. **Permanent Long-term 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 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***. **Note For Chiropractors**: Under the FMLA, a serious health condition involving chiropractic treatment is limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist. No X-rays are needed, but a statement that a subluxation was identified by X-rays should be provided.

__Patient hospitalized due to cardiovascular disorder. Patient suffering from abnormal heartbeat, shortness of breath and chest pain. Rx medications are prescribed and further medical testing and monitoring during the patient's hospital stay. _____

III. DURATION AND EXTENT OF LEAVE REQUIRED

What is the date the condition commenced? August 17, 2011

On which dates did you treat the Employee in the past 12 months? 1/3/15, 3/20/2015, 10/15/15

How long do you project the condition to continue? Lifetime to be reviewed annually

How long will the Employee be incapacitated (if different)? 6 weeks

How long will the Employee need to be on leave because of the condition? 6 to 12 weeks

Will the Employee need treatment at least twice per year for the condition? _X_ Yes ___ No

Will the Employee require intermittent leave or a reduced work schedule due either to planned medical treatment (for example, follow-up visits or physical therapy), or because of unforeseeable episodes of incapacity (for example, flare ups of symptoms)? _X Yes ___ No

If yes, please provide the following additional information:

Estimated dates of scheduled treatment:

Frequency of treatment/episodes of incapacity: __ times per ___week ___ month

Duration of treatment/episode of incapacity: ____hour(s) or ___ day(s)
(for example, 3 times per 1 month lasting 1-2 days per episode)

Period of Recovery: ___2 to 8 months

Is the Employee able to perform the essential functions of the Employee's position without physical restrictions, accommodations or modification of job duties? __ Yes _X_No

If no, can the Employee perform the essential functions of the job with physical restrictions, accommodations or modifications of job duties? __ Yes __X_No

If yes, describe the physical restrictions, accommodations or modification of job duties required:

IV. HEALTH CARE PROVIDER SIGNATURE

Signature: _____*Dr. Jane Brody*_____ Date: _____10/15/2015_____

Health Care Provider's Name (Please print): _Dr. Jane Brody_____

Address: _557 Roman Dr. Atlanta GA_____

Telephone Number: _____Fax Number: _____

Specialty/Type of Practice: _____Cardiology____

SAMPLE FORM EMPLOYEE MIGRAINE

CERTIFICATION OF EMPLOYEE'S SERIOUS HEALTH CONDITION FOR FAMILY AND MEDICAL LEAVE

This form must be completed by a Health Care Provider when FMLA leave is requested and medical documentation is required pursuant to 512.41, 513.36 and 515.5 of ELM. **In all instances the information on the form must relate only to the serious health condition for which the current need for leave exists.** ***Form PS 3971 also must be completed by employee and submitted to properly request FMLA leave.*** *PLEASE REVIEW THE COMPLETE FORM AND COMPLETE ALL SECTIONS THAT APPLY. FAILURE TO PROVIDE COMPLETE INFORMATION COULD RESULT IN DELAY OR DENIAL OF LEAVE REQUEST.*

I. EMPLOYEE INFORMATION

Employee's Name: Your Name Here

EIN: _____ FMLA Case # _____

II. CONDITION REQUIRING LEAVE

Please check the box below for the type of serious health condition the Employee has. ***See page 3 for a complete description of what constitutes a "serious health condition" for purposes of the FMLA.***

__ 1. **Hospital Care**
__ 2. **Absence Plus Treatment**
__ 3. **Pregnancy**
X_ 4. **Chronic Condition**
__ 5. **Permanent Long-term 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 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***. **Note For Chiropractors**: Under the FMLA, a serious health condition involving chiropractic treatment is limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist. No X-rays are needed, but a statement that a subluxation was identified by X-rays should be provided.

__Patient suffers from migraines that incapacitate the employee with symptoms that include nausea, vomiting, pain and sensitivity to light and noise on an intermittent basis. Rx medications and bed rest prescribed as a regimen of treatment._____

III. DURATION AND EXTENT OF LEAVE REQUIRED

What is the date the condition commenced? August 3 ,1997

On which dates did you treat the Employee in the past 12 months? 1/3/15, 3/20/2015, 11/20/15

How long do you project the condition to continue? Lifetime to be reviewed annually

How long will the Employee be incapacitated (if different)? 1-3 days

How long will the Employee need to be on leave because of the condition? _____

Lifetime to be reviewed annually

Will the Employee need treatment at least twice per year for the condition? _X_ Yes ___ No

Will the Employee require intermittent leave or a reduced work schedule due either to planned medical treatment (for example, follow-up visits or physical therapy), or because of unforeseeable episodes of incapacity (for example, flare ups of symptoms)? _X_ Yes ___ No

If yes, please provide the following additional information:

Estimated dates of scheduled treatment: _1 scheduled visit every 3 months for monitoring of medications

Frequency of treatment/episodes of incapacity: 1-3 times per ___week _1_ month

Duration of treatment/episode of incapacity: ____hour(s) or _1-3 day(s)
(for example, 3 times per 1 month lasting 1-2 days per episode)

Period of Recovery: _____

Is the Employee able to perform the essential functions of the Employee's position without physical restrictions, accommodations or modification of job duties? _X_ Yes __No

If no, can the Employee perform the essential functions of the job with physical restrictions, accommodations or modifications of job duties? __ Yes ___No

If yes, describe the physical restrictions, accommodations or modification of job duties required:

IV. HEALTH CARE PROVIDER SIGNATURE

Signature: *Dr. Jane Brody* Date: 11/20/2015

Health Care Provider's Name (Please print): Dr. Jane Brody

Address: 557 Roman Dr. Atlanta GA

Telephone Number: _____ Fax Number: _____

Specialty/Type of Practice: Neurology

SAMPLE FORM EMPLOYEE DIABETES

CERTIFICATION OF EMPLOYEE'S SERIOUS HEALTH CONDITION FOR FAMILY AND MEDICAL LEAVE

This form must be completed by a Health Care Provider when FMLA leave is requested and medical documentation is required pursuant to 512.41, 513.36 and 515.5 of ELM. **In all instances the information on the form must relate only to the serious health condition for which the current need for leave exists.** ***Form PS 3971 also must be completed by employee and submitted to properly request FMLA leave.*** *PLEASE REVIEW THE COMPLETE FORM AND COMPLETE ALL SECTIONS THAT APPLY. FAILURE TO PROVIDE COMPLETE INFORMATION COULD RESULT IN DELAY OR DENIAL OF LEAVE REQUEST.*

I. EMPLOYEE INFORMATION

Employee's Name: Your Name Here

EIN: _____ FMLA Case # _____

II. CONDITION REQUIRING LEAVE

Please check the box below for the type of serious health condition the Employee has. ***See page 3 for a complete description of what constitutes a "serious health condition" for purposes of the FMLA.***

__ 1. **Hospital Care**
__ 2. **Absence Plus Treatment**
__ 3. **Pregnancy**
X_ 4. **Chronic Condition**
__ 5. **Permanent Long-term 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 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***. **Note For Chiropractors**: Under the FMLA, a serious health condition involving chiropractic treatment is limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist. No X-rays are needed, but a statement that a subluxation was identified by X-rays should be provided.

__Patient has been diagnosed with diabetes which has not been controlled by RX medications and diet to date. The disorder incapacitates the employee due the fatigue, nausea, vomiting, blurred vision and numbness in hands and feet. _____

_____

III. DURATION AND EXTENT OF LEAVE REQUIRED

What is the date the condition commenced? _____January 2015__

On which dates did you treat the Employee in the past 12 months? 1/25/15, 2/5/2015

How long do you project the condition to continue? Lifetime to be reviewed annually

How long will the Employee be incapacitated (if different)? 1 to 3 days

How long will the Employee need to be on leave because of the condition?

Intermittently 6 months to 1 year

Will the Employee need treatment at least twice per year for the condition? _X_ Yes ___ No

Will the Employee require intermittent leave or a reduced work schedule due either to planned medical treatment (for example, follow-up visits or physical therapy), or because of unforeseeable episodes of incapacity (for example, flare ups of symptoms)? _X_ Yes ___ No

If yes, please provide the following additional information:

Estimated dates of scheduled treatment:

Frequency of treatment/episodes of incapacity: 1-5 times per ___week _1_ month

Duration of treatment/episode of incapacity: ____hour(s) or _1-3_ day(s)
(for example, 3 times per 1 month lasting 1-2 days per episode)

Period of Recovery:

Is the Employee able to perform the essential functions of the Employee's position without physical restrictions, accommodations or modification of job duties? _X_ Yes ___No

If no, can the Employee perform the essential functions of the job with physical restrictions, accommodations or modifications of job duties? __ Yes ___No

If yes, describe the physical restrictions, accommodations or modification of job duties required:

IV. HEALTH CARE PROVIDER SIGNATURE

Signature: *APWU* Date: xx/xx/xxxx

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

Address: 123 APWU Way

Telephone Number: xxx-xxx-xxxx Fax Number: xxx-xxx-xxxx

Specialty/Type of Practice: Internal Medicine

SAMPLE FORM EMPLOYEE MUSCULOSKELETAL

CERTIFICATION OF EMPLOYEE'S SERIOUS HEALTH CONDITION FOR FAMILY AND MEDICAL LEAVE

This form must be completed by a Health Care Provider when FMLA leave is requested and medical documentation is required pursuant to 512.41, 513.36 and 515.5 of ELM. **In all instances the information on the form must relate only to the serious health condition for which the current need for leave exists.** ***Form PS 3971 also must be completed by employee and submitted to properly request FMLA leave.*** *PLEASE REVIEW THE COMPLETE FORM AND COMPLETE ALL SECTIONS THAT APPLY. FAILURE TO PROVIDE COMPLETE INFORMATION COULD RESULT IN DELAY OR DENIAL OF LEAVE REQUEST.*

I. EMPLOYEE INFORMATION

Employee's Name: Your Name Here

EIN: _____ FMLA Case # _____

II. CONDITION REQUIRING LEAVE

Please check the box below for the type of serious health condition the Employee has. ***See page 3 for a complete description of what constitutes a "serious health condition" for purposes of the FMLA.***

__ 1. **Hospital Care** __ 3. **Pregnancy** __ 5. **Permanent Long-term Condition**

__ 2. **Absence Plus Treatment** X_ 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 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***. **Note For Chiropractors**: Under the FMLA, a serious health condition involving chiropractic treatment is limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist. No X-rays are needed, but a statement that a subluxation was identified by X-rays should be provided.

Patient suffers from *[list one of the following musculoskeletal disorders: spinal alignment ailments, fibromyalgia, repetitive motion injury, dislocation, lumbar sprains]* that incapacitates the employee on an intermittent basis. Rx medications and physical therapy prescribed as a course of treatment. X-rays demonstrate the patient has a subluxation of the spine._____

III. DURATION AND EXTENT OF LEAVE REQUIRED

What is the date the condition commenced? January 2015_

On which dates did you treat the Employee in the past 12 months? 1/3/15, 3/20/2015

How long do you project the condition to continue? Lifetime to be reviewed annually

How long will the Employee be incapacitated (if different)? 1-4 days

How long will the Employee need to be on leave because of the condition?

Intermittently up to 1 year

Will the Employee need treatment at least twice per year for the condition? _X_ Yes ___ No

Will the Employee require intermittent leave or a reduced work schedule due either to planned medical treatment (for example, follow-up visits or physical therapy), or because of unforeseeable episodes of incapacity (for example, flare ups of symptoms)? _X_ Yes ___ No

If yes, please provide the following additional information:

Estimated dates of scheduled treatment: _1 scheduled visit every 3 months for monitoring of medications and adjustment as needed

Frequency of treatment/episodes of incapacity: 1-3 times per ___week _1_ month

Duration of treatment/episode of incapacity: ____hour(s) or _1-2 day(s)
(for example, 3 times per 1 month lasting 1-2 days per episode)

Period of Recovery:

Is the Employee able to perform the essential functions of the Employee's position without physical restrictions, accommodations or modification of job duties? _X_ Yes __No

If no, can the Employee perform the essential functions of the job with physical restrictions, accommodations or modifications of job duties? __ Yes ___No

If yes, describe the physical restrictions, accommodations or modification of job duties required:

IV. HEALTH CARE PROVIDER SIGNATURE

Signature: *Dr. Martin Stein* Date: 3/20/2015

Health Care Provider's Name (Please print): Dr. Martin Stein

Address: 457 Lemon Ave, Chicago IL

Telephone Number: Fax Number:

Specialty/Type of Practice: Chiropratic

SAMPLE FORM EMPLOYEE PERMANENT LONG TERM

CERTIFICATION OF EMPLOYEE'S SERIOUS HEALTH CONDITION FOR FAMILY AND MEDICAL LEAVE

This form must be completed by a Health Care Provider when FMLA leave is requested and medical documentation is required pursuant to 512.41, 513.36 and 515.5 of ELM. **In all instances the information on the form must relate only to the serious health condition for which the current need for leave exists.** ***Form PS 3971 also must be completed by employee and submitted to properly request FMLA leave.*** *PLEASE REVIEW THE COMPLETE FORM AND COMPLETE ALL SECTIONS THAT APPLY. FAILURE TO PROVIDE COMPLETE INFORMATION COULD RESULT IN DELAY OR DENIAL OF LEAVE REQUEST.*

I. EMPLOYEE INFORMATION

Employee's Name: Your name here

EIN: _____ FMLA Case # _____

II. CONDITION REQUIRING LEAVE

Please check the box below for the type of serious health condition the Employee has. ***See page 3 for a complete description of what constitutes a "serious health condition" for purposes of the FMLA.***

__ 1. **Hospital Care**
__ 2. **Absence Plus Treatment**
__ 3. **Pregnancy**
__ 4. **Chronic Condition**
_X_ 5. **Permanent Long-term 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 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***. **Note For Chiropractors**: Under the FMLA, a serious health condition involving chiropractic treatment is limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist. No X-rays are needed, but a statement that a subluxation was identified by X-rays should be provided.

Patient has been diagnosed with having a massive stroke requiring extensive physical and speech therapy and medication

III. DURATION AND EXTENT OF LEAVE REQUIRED

What is the date the condition commenced? January 10, 2015

On which dates did you treat the Employee in the past 12 months? 1/10/2015, 2/5/2015

How long do you project the condition to continue? 1 year

How long will the Employee be incapacitated (if different)? 6 to 8 months

How long will the Employee need to be on leave because of the condition? 6 to 12 months

Will the Employee need treatment at least twice per year for the condition? _X__ Yes ___ No

Will the Employee require intermittent leave or a reduced work schedule due either to planned medical treatment (for example, follow-up visits or physical therapy), or because of unforeseeable episodes of incapacity (for example, flare ups of symptoms)? __X_Yes ___ No

If yes, please provide the following additional information:

Estimated dates of scheduled treatment: 3 times a week for 6 months beginning 2/2015

Frequency of treatment/episodes of incapacity:_12_ times per __week _1_ month

Duration of treatment/episode of incapacity: _8___hour(s) or ____ day(s)
(for example, 3 times per 1 month lasting 1-2 days per episode)

Period of Recovery: _____6 to 8 months___

Is the Employee able to perform the essential functions of the Employee's position without physical restrictions, accommodations or modification of job duties? __X_ Yes ___No

If no, can the Employee perform the essential functions of the job with physical restrictions, accommodations or modifications of job duties? ___ Yes ___No

If yes, describe the physical restrictions, accommodations or modification of job duties required: _____

IV. HEALTH CARE PROVIDER SIGNATURE

Signature: _____*Dr. Paul Finkle*_____ Date:_____2/5/15_____

Health Care Provider's Name (Please print): __Dr. Paul Finkle_____

Address: _166 Astor Ct Madison WI_____

Telephone Number: _____Fax Number: _____

Specialty/Type of Practice: _Neurology_____

SAMPLE FORM EMPLOYEE PREGNANCY

CERTIFICATION OF EMPLOYEE'S SERIOUS HEALTH CONDITION FOR FAMILY AND MEDICAL LEAVE

This form must be completed by a Health Care Provider when FMLA leave is requested and medical documentation is required pursuant to 512.41, 513.36 and 515.5 of ELM. **In all instances the information on the form must relate only to the serious health condition for which the current need for leave exists.** ***Form PS 3971 also must be completed by employee and submitted to properly request FMLA leave.*** *PLEASE REVIEW THE COMPLETE FORM AND COMPLETE ALL SECTIONS THAT APPLY. FAILURE TO PROVIDE COMPLETE INFORMATION COULD RESULT IN DELAY OR DENIAL OF LEAVE REQUEST.*

I. EMPLOYEE INFORMATION

Employee's Name: Your Name Here

EIN: _____ FMLA Case # _____

II. CONDITION REQUIRING LEAVE

Please check the box below for the type of serious health condition the Employee has. ***See page 3 for a complete description of what constitutes a "serious health condition" for purposes of the FMLA.***

__ 1. **Hospital Care** _X_ 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 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***. **Note For Chiropractors**: Under the FMLA, a serious health condition involving chiropractic treatment is limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist. No X-rays are needed, but a statement that a subluxation was identified by X-rays should be provided.

Patient is pregnant and requires intermittent prenatal care, and may be intermittently incapacitated due to nausea, vomiting, pain and fatigue.

III. DURATION AND EXTENT OF LEAVE REQUIRED

What is the date the condition commenced? January 5, 2015 (approx.)

On which dates did you treat the Employee in the past 12 months? 2/3/2015, 3/5/2015

How long do you project the condition to continue? 7-8 months

How long will the Employee be incapacitated (if different)? Intermittently throughout pregnancy, and 6-8 weeks after delivery

How long will the Employee need to be on leave because of the condition? Up to 2 times per week lasting 1-3 days per episode throughout pregnancy, and 6-8 weeks after delivery

Will the Employee need treatment at least twice per year for the condition? _X_ Yes ___ No

Will the Employee require intermittent leave or a reduced work schedule due either to planned medical treatment (for example, follow-up visits or physical therapy), or because of unforeseeable episodes of incapacity (for example, flare ups of symptoms)? X__Yes ___ No

If yes, please provide the following additional information:

Estimated dates of scheduled treatment: prenatal visits 1 time per month for 6 months; visits will increase to 2-3 visits per month in last 3 months of pregnancy.

Frequency of treatment/episodes of incapacity: _2_ times per _1_week ___ month

Duration of treatment/episode of incapacity: ____hour(s) or _1-3_ day(s)
(for example, 3 times per 1 month lasting 1-2 days per episode)

Period of Recovery: 1-3 day per episode for periodic incapacitation during pregnancy; recovery after pregnancy expected to last 6-8 weeks

Is the Employee able to perform the essential functions of the Employee's position without physical restrictions, accommodations or modification of job duties? __ Yes __X_No

If no, can the Employee perform the essential functions of the job with physical restrictions, accommodations or modifications of job duties? __X_ Yes ___No

If yes, describe the physical restrictions, accommodations or modification of job duties required: Employee restricted from lifting more than 10 pounds during pregnancy *[adjust as necessary or delete if it does not apply]*

IV. HEALTH CARE PROVIDER SIGNATURE

Signature: *Dr. Saul Shapiro* Date: March 5, 2015

Health Care Provider's Name (Please print): Dr. Saul Shapiro

Address: 9585 Baylor Ave. Brighton Beach NY

Telephone Number: _____ Fax Number: _____

Specialty/Type of Practice: OB/GYN

SAMPLE FORM SPOUSE ABSENCE PLUS TREATMENT

CERTIFICATION OF FAMILY MEMBER'S SERIOUS HEALTH CONDITION FOR FAMILY AND MEDICAL LEAVE

This form must be completed by a health care provider when FMLA leave is requested and medical documentation is required pursuant to 512.41, 513.36 and 515.5 of ELM. **In all instances the information on the form must relate only to the serious health condition for which the current need for leave exists.** ***Form PS 3971 also must be completed by employee and submitted to properly request FMLA leave.*** *PLEASE REVIEW THE COMPLETE FORM AND COMPLETE ALL SECTIONS THAT APPLY. FAILURE TO PROVIDE COMPLETE INFORMATION COULD RESULT IN DELAY OR DENIAL OF LEAVE REQUEST.*

I. EMPLOYEE INFORMATION

Employee's Name: Your Name Here

EIN: _____ FMLA Case # _____

Name of Patient: _____

Relationship of Employee to patient for whom leave is requested: spouse
(Spouse, Parent, Child; child over 18 must be incapable of self-care because of disability)

II. CONDITION REQUIRING LEAVE

Please check the box below for the type of serious health condition the patient has. ***See page 3 for a complete description of what constitutes a "serious health condition" for purposes of the FMLA.***

__ 1. **Hospital Care** __ 3. **Pregnancy** __ 5. **Permanent Long-term Condition**

__X 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 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***. **Note for Chiropractors**: Under the FMLA, a serious health condition involving chiropractic treatment is limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist. No X-rays are needed, but a statement that a subluxation was identified by X-rays should be provided.

_The employee's spouse underwent Hernia repair surgery that requires the employee to care for the spouse's needs during recovery and provide transportation to and from follow up visits lasting 3 days or more._____

III. DURATION AND EXTENT OF LEAVE REQUIRED

What is the date the condition commenced? Oct 10, 2015

On which dates did you treat the patient in the past 12 months? 10/10/15, 12/7/15

How long do you project the condition to continue? 3 months

How long will the patient be incapacitated (if different)? _____

Does the patient require assistance to meet basic medical, hygiene, nutritional, safety or transportation needs because of the condition or during periods of incapacity? _X_ Yes ___ No

If not, would the Employee's presence provide psychological comfort beneficial to the patient's recovery? _X_ Yes ___ No

How long will the Employee need to be on leave to care for the patient? 3 months

Will the patient need treatment at least twice per year for the condition? __X_ Yes ___ No

Will the Employee require intermittent leave or a reduced work schedule due either to planned medical treatment of the patient (for example, follow-up visits or physical therapy), or because of unforeseeable episodes of the patient's incapacity (for example, flare ups)? _X_ Yes _ No

If yes, please provide the following additional information:

Estimated dates of scheduled treatment: 1/14/16 and 2/1/16

Frequency of treatment/episodes of incapacity: _1-3_ times per _week _1_ month

Duration of treatment/episode of incapacity: ____hour(s) or _3_ day(s)
(for example, 3 times per 1 month lasting 1-2 days per episode)

Period of Recovery: _____3 months_____

IV. HEALTH CARE PROVIDER SIGNATURE

Signature: ____*Dr. Hank Bishop*_____ Date: _____12/7/15_____

Health Care Provider's Name (Please print): _____Dr. Hank Bishop_____

Address: _574 Lakewood Dr., Tampa FL_____

Telephone Number: _____Fax Number: _____

Specialty/Type of Practice: _____GENERAL SURGEON_____

SAMPLE FORM CHILD CHRONIC ASTHMA

CERTIFICATION OF FAMILY MEMBER'S SERIOUS HEALTH CONDITION FOR FAMILY AND MEDICAL LEAVE

This form must be completed by a health care provider when FMLA leave is requested and medical documentation is required pursuant to 512.41, 513.36 and 515.5 of ELM. **In all instances the information on the form must relate only to the serious health condition for which the current need for leave exists.** ***Form PS 3971 also must be completed by employee and submitted to properly request FMLA leave.*** *PLEASE REVIEW THE COMPLETE FORM AND COMPLETE ALL SECTIONS THAT APPLY. FAILURE TO PROVIDE COMPLETE INFORMATION COULD RESULT IN DELAY OR DENIAL OF LEAVE REQUEST.*

I. EMPLOYEE INFORMATION

Employee's Name: Your Name Here

EIN: _____ FMLA Case # _____

Name of Patient: _____

Relationship of Employee to patient for whom leave is requested: child
(Spouse, Parent, Child; child over 18 must be incapable of self-care because of disability)

II. CONDITION REQUIRING LEAVE

Please check the box below for the type of serious health condition the patient has. ***See page 3 for a complete description of what constitutes a "serious health condition" for purposes of the FMLA.***

__ 1. **Hospital Care** __ 3. **Pregnancy** __ 5. **Permanent Long-term Condition**

__ 2. **Absence Plus Treatment** _X 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 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***. **Note for Chiropractors**: Under the FMLA, a serious health condition involving chiropractic treatment is limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist. No X-rays are needed, but a statement that a subluxation was identified by X-rays should be provided.

_The employee's child suffers from a respiratory condition that causes shortness of breath, wheezing and chest pain. Parent needs to administer RX medications and provide nutritional and

transportation needs.

III. DURATION AND EXTENT OF LEAVE REQUIRED

What is the date the condition commenced? May 15, 2005

On which dates did you treat the patient in the past 12 months? 1/10/15, 2/7/15, 4/25/15

How long do you project the condition to continue? Lifetime to be reviewed annually

How long will the patient be incapacitated (if different)? 1 week

Does the patient require assistance to meet basic medical, hygiene, nutritional, safety or transportation needs because of the condition or during periods of incapacity? _X_ Yes ___ No

If not, would the Employee's presence provide psychological comfort beneficial to the patient's recovery? _X_ Yes ___ No

How long will the Employee need to be on leave to care for the patient? 1 to 3 times a month with episodes lasting up to 4 days.

Will the patient need treatment at least twice per year for the condition? __X_ Yes ___ No

Will the Employee require intermittent leave or a reduced work schedule due either to planned medical treatment of the patient (for example, follow-up visits or physical therapy), or because of unforeseeable episodes of the patient's incapacity (for example, flare ups)? _X_ Yes _No

If yes, please provide the following additional information:

Estimated dates of scheduled treatment: _____

Frequency of treatment/episodes of incapacity: _1-3_ times per _week _1_ month

Duration of treatment/episode of incapacity: ____hour(s) or 1-4_ day(s)
(for example, 3 times per 1 month lasting 1-2 days per episode)

Period of Recovery: _____

IV. HEALTH CARE PROVIDER SIGNATURE

Signature: ____*Dr. Ted Meyer*_____ Date: _____4/25/15_____

Health Care Provider's Name (Please print): _____Dr. Ted Meyer_____

Address: _574 Willow St, Sarasota FL_____

Telephone Number: _____Fax Number: _____

Specialty/Type of Practice: _____Pediatrician_____

SAMPLE FORM SPOUSE HOSPITAL STAY

CERTIFICATION OF FAMILY MEMBER'S SERIOUS HEALTH CONDITION FOR FAMILY AND MEDICAL LEAVE

This form must be completed by a health care provider when FMLA leave is requested and medical documentation is required pursuant to 512.41, 513.36 and 515.5 of ELM. **In all instances the information on the form must relate only to the serious health condition for which the current need for leave exists.** ***Form PS 3971 also must be completed by employee and submitted to properly request FMLA leave.*** *PLEASE REVIEW THE COMPLETE FORM AND COMPLETE ALL SECTIONS THAT APPLY. FAILURE TO PROVIDE COMPLETE INFORMATION COULD RESULT IN DELAY OR DENIAL OF LEAVE REQUEST.*

I. EMPLOYEE INFORMATION

Employee's Name: Your Name Here

EIN: _____ FMLA Case # _____

Name of Patient: _____

Relationship of Employee to patient for whom leave is requested: spouse
(Spouse, Parent, Child; child over 18 must be incapable of self-care because of disability)

II. CONDITION REQUIRING LEAVE

Please check the box below for the type of serious health condition the patient has. ***See page 3 for a complete description of what constitutes a "serious health condition" for purposes of the FMLA.***

_X_ 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 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***. **Note for Chiropractors**: Under the FMLA, a serious health condition involving chiropractic treatment is limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist. No X-rays are needed, but a statement that a subluxation was identified by X-rays should be provided.

_The employee's spouse has been hospitalized due to a cardiac condition that has rendered the spouse incapacitated. Employee is needed to provide assistance with medical, nutritional and transportation needs. _____

III. DURATION AND EXTENT OF LEAVE REQUIRED

What is the date the condition commenced? Feb 19, 2015

On which dates did you treat the patient in the past 12 months? 2/19/2015, 3/21/2015, 4/28/2015

How long do you project the condition to continue? Up to 6 months

How long will the patient be incapacitated (if different)? 8 weeks

Does the patient require assistance to meet basic medical, hygiene, nutritional, safety or transportation needs because of the condition or during periods of incapacity? _X Yes ___ No

If not, would the Employee's presence provide psychological comfort beneficial to the patient's recovery? _X Yes ___ No

How long will the Employee need to be on leave to care for the patient? 8 weeks

Will the patient need treatment at least twice per year for the condition? __X_ Yes ___ No

Will the Employee require intermittent leave or a reduced work schedule due either to planned medical treatment of the patient (for example, follow-up visits or physical therapy), or because of unforeseeable episodes of the patient's incapacity (for example, flare ups)? ___Yes X No

If yes, please provide the following additional information:

Estimated dates of scheduled treatment: _____

Frequency of treatment/episodes of incapacity: ___ times per _week __ month

Duration of treatment/episode of incapacity: ____hour(s) or ___ day(s)
(for example, 3 times per 1 month lasting 1-2 days per episode)

Period of Recovery: 8 to 12 weeks

IV. HEALTH CARE PROVIDER SIGNATURE

Signature: *Dr. Hank Bishop* Date: 4/28/15

Health Care Provider's Name (Please print): Dr. Hank Bishop

Address: 574 Lakewood Dr, Tampa FL

Telephone Number: _____ Fax Number: _____

Specialty/Type of Practice: orthopedic

SAMPLE FORM FAMILY MULTIPLE TREATMENTS

CERTIFICATION OF FAMILY MEMBER'S SERIOUS HEALTH CONDITION FOR FAMILY AND MEDICAL LEAVE

This form must be completed by a health care provider when FMLA leave is requested and medical documentation is required pursuant to 512.41, 513.36 and 515.5 of ELM. **In all instances the information on the form must relate only to the serious health condition for which the current need for leave exists.** ***Form PS 3971 also must be completed by employee and submitted to properly request FMLA leave.*** *PLEASE REVIEW THE COMPLETE FORM AND COMPLETE ALL SECTIONS THAT APPLY. FAILURE TO PROVIDE COMPLETE INFORMATION COULD RESULT IN DELAY OR DENIAL OF LEAVE REQUEST.*

I. EMPLOYEE INFORMATION

Employee's Name: Your Name Here

EIN: _____ FMLA Case # _____

Name of Patient: _____

Relationship of Employee to patient for whom leave is requested: child
(Spouse, Parent, Child; child over 18 must be incapable of self-care because of disability)

II. CONDITION REQUIRING LEAVE

Please check the box below for the type of serious health condition the patient has. ***See page 3 for a complete description of what constitutes a "serious health condition" for purposes of the FMLA.***

__ 1. **Hospital Care**
__ 2. **Absence Plus Treatment**
__ 3. **Pregnancy**
__ 4. **Chronic Condition**
__ 5. **Permanent Long-term Condition**
_X_ 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 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***. **Note For Chiropractors**: Under the FMLA, a serious health condition involving chiropractic treatment is limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist. No X-rays are needed, but a statement that a subluxation was identified by X-rays should be provided.

The employee's child underwent surgery for an ACL injury and will require physical therapy as a regimen of treatment. Employee will assist in daily life functions during the recovery period.

III. DURATION AND EXTENT OF LEAVE REQUIRED

What is the date the condition commenced? Feb 19, 2015

On which dates did you treat the patient in the past 12 months? 2/19/2015, 3/21/2015, 4/28/2015

How long do you project the condition to continue? Up to 6 months

How long will the patient be incapacitated (if different)? 8 weeks

Does the patient require assistance to meet basic medical, hygiene, nutritional, safety or transportation needs because of the condition or during periods of incapacity? __X_ Yes ___ No

If not, would the Employee's presence provide psychological comfort beneficial to the patient's recovery? ___Yes ___ No

How long will the Employee need to be on leave to care for the patient? 2 weeks after surgery and additional 6 weeks intermittently for scheduled appointments and therapy

Will the patient need treatment at least twice per year for the condition? __X_ Yes ___ No

Will the Employee require intermittent leave or a reduced work schedule due either to planned medical treatment of the patient (for example, follow-up visits or physical therapy), or because of unforeseeable episodes of the patient's incapacity (for example, flare ups)? __X_Yes ___ No

If yes, please provide the following additional information:

Estimated dates of scheduled treatment: 5/10/15, 5/28/15. 6/4/15, therapy 1 time per week for 8 weeks

Frequency of treatment/episodes of incapacity: _4-5_ times per _week _1_ month

Duration of treatment/episode of incapacity: ____hour(s) or _1___ day(s)
(for example, 3 times per 1 month lasting 1-2 days per episode)

Period of Recovery: 8 to 12 weeks

IV. HEALTH CARE PROVIDER SIGNATURE

Signature: *Dr. Hank Bishop* Date: 4/28/15

Health Care Provider's Name (Please print): Dr. Hank Bishop

Address: 574 Lakewood Dr, Tampa Fl

Telephone Number: _____ Fax Number: _____

Specialty/Type of Practice: orthopedic

SAMPLE FORM SPOUSE PERMANENT LONG TERM

CERTIFICATION OF FAMILY MEMBER'S SERIOUS HEALTH CONDITION FOR FAMILY AND MEDICAL LEAVE

This form must be completed by a health care provider when FMLA leave is requested and medical documentation is required pursuant to 512.41, 513.36 and 515.5 of ELM. **In all instances the information on the form must relate only to the serious health condition for which the current need for leave exists.** ***Form PS 3971 also must be completed by employee and submitted to properly request FMLA leave.*** *PLEASE REVIEW THE COMPLETE FORM AND COMPLETE ALL SECTIONS THAT APPLY. FAILURE TO PROVIDE COMPLETE INFORMATION COULD RESULT IN DELAY OR DENIAL OF LEAVE REQUEST.*

I. EMPLOYEE INFORMATION

Employee's Name: Your Name Here

EIN: _____ FMLA Case # _____

Name of Patient: _____

Relationship of Employee to patient for whom leave is requested: spouse
(Spouse, Parent, Child; child over 18 must be incapable of self-care because of disability)

II. CONDITION REQUIRING LEAVE

Please check the box below for the type of serious health condition the patient has. ***See page 3 for a complete description of what constitutes a "serious health condition" for purposes of the FMLA.***

__ 1. **Hospital Care** ___ 3. **Pregnancy** _X_ 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 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***. **Note for Chiropractors**: Under the FMLA, a serious health condition involving chiropractic treatment is limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist. No X-rays are needed, but a statement that a subluxation was identified by X-rays should be provided.

The employee's spouse suffers from a liver disorder/disease that requires medical treatment and long-term care. The treatment prescribed causes a number of side effects that render the spouse

incapable of self-care. Side effects include fatigue, anemia, nausea, diarrhea, depression, headaches and flu-like symptoms.

III. DURATION AND EXTENT OF LEAVE REQUIRED

What is the date the condition commenced? Feb 18, 2008

On which dates did you treat the patient in the past 12 months? 4/19/2015, 5/21/2015

How long do you project the condition to continue? Lifetime to be review annually

How long will the patient be incapacitated (if different)? 3 to 6 months

Does the patient require assistance to meet basic medical, hygiene, nutritional, safety or transportation needs because of the condition or during periods of incapacity? _X_ Yes ___ No

If not, would the Employee's presence provide psychological comfort beneficial to the patient's recovery? _X_ Yes ___ No

How long will the Employee need to be on leave to care for the patient? 3 to 6 months

Will the patient need treatment at least twice per year for the condition? __X_ Yes ___ No

Will the Employee require intermittent leave or a reduced work schedule due either to planned medical treatment of the patient (for example, follow-up visits or physical therapy), or because of unforeseeable episodes of the patient's incapacity (for example, flare ups)? _X_ Yes __No

If yes, please provide the following additional information:

Estimated dates of scheduled treatment: _7/3/15, 8/4/15, 9/5/15, 10/4/15

Frequency of treatment/episodes of incapacity: _1-4_ times per _week _1_ month

Duration of treatment/episode of incapacity: ____hour(s) or _1-4 day(s)
(for example, 3 times per 1 month lasting 1-2 days per episode)

Period of Recovery: __1 to 4 days after each treatment.

IV. HEALTH CARE PROVIDER SIGNATURE

Signature: ____*Dr. Joan Miller*_____ Date: _____6/26/15_____

Health Care Provider's Name (Please print): _____Dr. Joan Miller_____

Address: _574 Maple Ave Huntington WV_____

Telephone Number: _____Fax Number: _____

Specialty/Type of Practice: _____Internal Medicine_____

SAMPLE FORM SPOUSE PREGNANCY

CERTIFICATION OF FAMILY MEMBER'S SERIOUS HEALTH CONDITION FOR FAMILY AND MEDICAL LEAVE

This form must be completed by a health care provider when FMLA leave is requested and medical documentation is required pursuant to 512.41, 513.36 and 515.5 of ELM. **In all instances the information on the form must relate only to the serious health condition for which the current need for leave exists.** ***Form PS 3971 also must be completed by employee and submitted to properly request FMLA leave.*** *PLEASE REVIEW THE COMPLETE FORM AND COMPLETE ALL SECTIONS THAT APPLY. FAILURE TO PROVIDE COMPLETE INFORMATION COULD RESULT IN DELAY OR DENIAL OF LEAVE REQUEST.*

I. EMPLOYEE INFORMATION

Employee's Name: Your Name Here

EIN: _____ FMLA Case # _____

Name of Patient: _____

Relationship of Employee to patient for whom leave is requested: spouse
(Spouse, Parent, Child; child over 18 must be incapable of self-care because of disability)

II. CONDITION REQUIRING LEAVE

Please check the box below for the type of serious health condition the patient has. ***See page 3 for a complete description of what constitutes a "serious health condition" for purposes of the FMLA.***

__ 1. **Hospital Care** __X 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 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***. **Note for Chiropractors**: Under the FMLA, a serious health condition involving chiropractic treatment is limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist. No X-rays are needed, but a statement that a subluxation was identified by X-rays should be provided.

The employee's spouse is pregnant and requires assistance with prenatal care as well as transportation needs to and from medical appointments.

III. DURATION AND EXTENT OF LEAVE REQUIRED

What is the date the condition commenced? Feb 14, 2015 (approx.)

On which dates did you treat the patient in the past 12 months? 4/19/2015, 5/21/2015

How long do you project the condition to continue? 7-8 months

How long will the patient be incapacitated (if different)? Intermittently during pregnancy; 6-8 weeks after delivery

Does the patient require assistance to meet basic medical, hygiene, nutritional, safety or transportation needs because of the condition or during periods of incapacity? _X_ Yes ___ No

If not, would the Employee's presence provide psychological comfort beneficial to the patient's recovery? ___Yes ___ No

How long will the Employee need to be on leave to care for the patient? 7-8 months

Will the patient need treatment at least twice per year for the condition? __X_ Yes ___ No

Will the Employee require intermittent leave or a reduced work schedule due either to planned medical treatment of the patient (for example, follow-up visits or physical therapy), or because of unforeseeable episodes of the patient's incapacity (for example, flare ups)? _X_ Yes __No

If yes, please provide the following additional information:

Estimated dates of scheduled treatment: _6/20/15 7/19/15, appts scheduled once a month until last trimester when appts will increase to 4 times a month. Due date 11/10/15

Frequency of treatment/episodes of incapacity: _1-4_ times per _week _1_ month

Duration of treatment/episode of incapacity: ____hour(s) or _1 day(s)
(for example, 3 times per 1 month lasting 1-2 days per episode)

Period of Recovery: __6-8 weeks after delivery

IV. HEALTH CARE PROVIDER SIGNATURE

Signature: ____*Dr. Joan Miller*_____ Date: _____4/28/15_____

Health Care Provider's Name (Please print): _____Dr. Joan Miller_____

Address: _574 Skyview Lane, Detroit MI_____

Telephone Number: _____Fax Number: _____

Specialty/Type of Practice: _____OB/GYN_____

APWU

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