Human Resource Services
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HEALTH CARE PROVIDER'S CERTIFICATION OF NEED FOR FAMILY OR MEDICAL LEAVE

Under the provisions of the Family and Medical Leave Act (FMLA)
THIS FORM IS COMPLETED BY THE HEALTH CARE PROVIDER.
THIS FORM IS AVAILABLE AND CAN BE COMPLETED ON-LINE AT
http://www.marshall.edu/human-resources/forms/FMLA-Health-Care-Providers-Certification-1.pdf

Employee's Name	
Patient's Name (if different)	

1. This form is to be completed and signed by the employee or patient's health care provider. The *serious health conditions* that qualify for leave under the federal Family and Medical Leave Act (FMLA) are listed below. Please indicate by check mark in the appropriate box below which category the patient's condition qualifies under. Here and elsewhere on this form, the information sought relates only to the condition for which the employee is requesting FMLA leave. 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 consecutive days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves: (1) Treatment[1] two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider; or (2) Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment[2] 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: (1) Requires periodic visits for treatment by a health care provider, or by a nurse or physician's assistant under direct supervision of a health care provider; (2) Continues over an extended period of time (including recurring episodes of a single underlying condition); and (3) May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).
	5. **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).
	None of the above.

2. Describe the medical facts that support your certification, including a brief statement about how the medical facts meet the criteria of one of the above categories.			
3. State the approximate date the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present incapacity[3] if different).			
4. Will it be necessary for the employee to work only intermittently or to work on a less than full schedule as a result of the condition (including for treatment described in item 6 above).			
	YES		NO
If yes, give the probable duration.			
5. If the condition is a chronic condition (4, above) or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity.			
6. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments.			
7. If the patient will be absent from work or other daily activities because of treatment on an intermittent or part-time basis, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any.			
8. If any of these treatments will be provided by another provider of health services (e.g., physical therapist), please state the nature of the treatments.			
9. If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment, etc.).			
10. If a medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind?			
	YES		NO

11. If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job? (The employee or the employer can on request supply you with a statement of essential job functions.)			
	YES		NO
If yes, please list the essential functions the employee is unable to perform.			
12. If neither 10 nor 11 above applies, is it necessary for the employee to be absent from work for treatment?			
	YES		NO
13. If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs, or safety, or for transportation?			
	YES		NO
If NO, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery?			
	YES		NO
14. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need.			

Printed name of health care provider	
Signature of health care provider	
Type of practice	
Address	
Address	
City, State, ZIP	
Telephone Number	

To be completed by the employee needing family leave to care for a family member:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule.	
Employee Signature	
Date	

NOTES:

[1] 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.

[2] 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 activities that can be initiated without a visit to a health care provider.

[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 therefore, or recovery therefrom.

The employee and the employee's supervisor are notified by Human Resource Services if leave under the FMLA is approved.

DISTRIBUTION: Original - Human Resource Services, Marshall University
Copy – Health Care Provider
Copy – Employee or Patient

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THIS IS PAGE FOUR OF A FOUR-PAGE FORM.