Leave of Absence - Certification of Health Care Provider for Family Member's Serious Health Condition

Employee Name_____

Department_____

INSTRUCTIONS to the EMPLOYEE: Please complete this section before giving this form to your family member or his/her medical provider.

Name of family member for whom you will provide care:_____
First Middle Last

Relationship of family member to you:
_____

If family member is your son or daughter, date of birth: _____

Describe care you will provide to your family member and estimate leave needed to provide care: _____
_____
_____
_____
_____

_____ _____
Employee Signature Date

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave to care for a family member. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's Name and Business Address:_____

Type of practice / Medical Specialty:_____

Telephone:_____Fax:_____

PART A: MEDICAL FACTS

Approximate date condition commenced:_____

Probable duration of condition:_____

Mark below as applicable:
Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ___No ___ Yes. If so, dates of admission:
_____

Date(s) you treated the patient for condition:
_____
Will the patient need to have treatment visits at least twice per year due to the condition?
___No ___ Yes.

Was medication, other than over-the-counter medication, prescribed? ___No ___Yes

Was the patient referred to another health care provider(s) for evaluation or treatment (e.g., physical therapist)? ____No ____Yes.

If so, state the nature of such treatments and expected duration of treatment:
_____

Is the medical condition pregnancy? ___No ___Yes.
If so, expected delivery date: _____

Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):
_____
_____
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PART B: AMOUNT OF CARE NEEDED: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic

medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No ___Yes.
Estimate the beginning and ending dates for the period of incapacity: _____
During this time, will the patient need care? __ No __ Yes.
Explain the care needed by the patient and why such care is medically necessary:
_____
_____
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Will the patient require follow-up treatments, including any time for recovery? ___No ___Yes.
Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:
_____
_____

Explain the care needed by the patient, and why such care is medically necessary:_____
_____
_____

Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? __ No __ Yes.
Estimate the hours the patient needs care on an intermittent basis, if any:
_____ hour(s) per day; _____ days per week from _____ through _____

Explain the care needed by the patient, and why such care is medically necessary:_____
_____
_____
_____
_____

Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ____No ____Yes.

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s)
Duration: _____ hours or ___ day(s) per episode
Does the patient need care during these flare-ups? ____ No ____ Yes.

Explain the care needed by the patient, and why such care is medically necessary:_____
_____
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ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

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Signature of Health Care Provider Date