Certification of Health Care Provider

(Family and Medical Leave Act of 1993)
(Alaska Family Leave Act)

This form is to be completed when the employee needs family leave to care for a FAMILY MEMBER with a "serious health condition."

Employee's Name:_____ SSN:_____

Patient's Name:_____

Relationship to Employee:_____

Release of Medical Information: I authorize the release of any medical information necessary to provide the information requested on this form.

Patient's Signature:_____ Date:_____

SERIOUS HEALTH CONDITION:

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

   _____ (1) Hospital Care
   _____ (2) Absence Plus Treatment
   _____ (3) Pregnancy
   _____ (4) Chronic Conditions Requiring Treatments
   _____ (5) Permanent/Long-Term Conditions Requiring Supervision
   _____ (6) Multiple Treatments (Non-Chronic Conditions)
   _____ None of the above.

   Date condition commenced:_____
   Probable duration of condition:_____

2. Describe the **medical facts** which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

TREATMENTS:

3. Will the patient be absent from work or other daily activities because of **treatment** on an **intermittent** or **part-time** basis?

   _____ Yes
   _____ No
   If Yes: Number of treatments:_____
   Interval between treatments:_____
   Dates of treatments:_____
   Period of recovery:_____

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

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

5. 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):

INCAPACITY:

6. Is the patient **presently incapacitated**[2]?

_____ Yes
_____ No
If yes, give the probable duration:_____

7. If the condition is a **chronic condition** (condition #4) or **pregnancy**, are **episodes of incapacity likely**?

_____ Yes
_____ No
If yes, give the probable duration of episodes:_____
If yes, give the probable frequency of episodes:_____

CARE PROVIDED:

8. **Does the patient require assistance** for basic medical or personal needs or safety, or for transportation?

_____ Yes
_____ No
If yes, give the probable duration:_____

9. Would the employee's presence to provide **psychological comfort** be beneficial to the patient or assist in the patient's recovery?

_____ Yes
_____ No
If yes, give the probable duration:_____

_____

(Signature of Health Care Provider) (Type of Practice) (Date)

_____

(Address) (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. Attach a proposed 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)

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

Family and Medical Leave Act of 1993 Information Sheet

For purposes of FMLA, **"serious health condition"** means an illness, injury, impairment, or physical or mental condition that involves one or more of the following:

1. **Hospital Care**
Inpatient care[1] (*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 calendar days** (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:

   (1) **Treatment**[2] **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**[3] **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), or kidney disease (dialysis).

[1] Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.
[2] Treatment includes examination to determine if a serious health condition exists and evaluation of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.
[3] 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, or other similar activities that can be initiated without a visit to a health care provider.