MUSC
MEDICAL UNIVERSITY of SOUTH CAROLINA

CERTIFICATION
of
HEALTH CARE PROVIDER
(Family and Medical Leave Act of 1993)

1. EMPLOYEE'S NAME _____

2. PATIENT'S NAME (if different from employee) _____

3. SERIOUS HEALTH CONDITION
Does the patient's condition[1] qualify under any of the **serious health condition** categories below? _____
If so, please check the applicable category:

☐ Hospital Care
Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity[2] or subsequent treatment in connection with or consequent to such inpatient care.

☐ Absence Plus Treatment
A period of incapacity[2] of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity[2] relating to the same condition), that also involves:
- **Treatment**[3] **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
- **Treatment** by a health care provider on **at least one occasion** which results in a **regimen of continuing treatment**[4] under the supervision of the health care provider.

☐ Pregnancy
Any period of incapacity due to **pregnancy**, or for **prenatal care**.

☐ Chronic Conditions Requiring Treatments,
A chronic condition which:
- 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;
- Continues over an **extended period of time** (including recurring episodes of a single underlying condition); and
- May cause **episodic** rather than a continuing period of incapacity[2] (e.g., asthma, diabetes, epilepsy, etc.).

☐ Permanent/Long-term Conditions Requiring Supervision
A period of **Incapacity**[2] 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.

☐ 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**[2] **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), and kidney disease (dialysis).

4. MEDICAL FACTS

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

_____

_____

_____

_____

_____

5. CONDITION AND INCAPACITATION

a. Indicate:

- the approximate **date** the condition commenced: _____
- the probable duration of the condition: _____
- the probable duration of the patient's present **incapacity**[2] if different: _____

b. 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 below)? _____

If yes, give the probable duration: _____

c. If the condition is a **chronic condition** or **pregnancy**, indicate:

- whether the patient is presently incapacitated[2] _____
- the likely duration and frequency of **episodes of incapacity**[2]: _____

6. ADDITIONAL TREATMENTS

a. If additional **treatments** will be required for the condition,

- provide an estimate of the probable number of such treatments: _____
- 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 of and interval between such treatments: _____
  - actual or estimated dates of treatment, if known: _____
  - period required for recovery, if any: _____

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

_____

_____

_____

_____

c. **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):

_____

_____

_____

_____

7. ABSENCE FROM WORK AND ESSENTIAL JOB FUNCTIONS

a. If 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? _____

b. 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 should supply you with information about the essential job functions)? _____
If yes, please list the essential functions the employee is unable to perform:
_____
_____
_____
_____

c. If neither a. nor b. applies, is it necessary for the employee to be **absent from work for treatment**? _____

8. CARE FOR A FAMILY MEMBER

a. 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?
_____

b. If no, would the employee's presence to provide **psychological comfort** be beneficial to the patient or assist in the patient's recovery? _____

c. If the patient will need care only **intermittently** or on a part-time basis, please indicate the probable **duration** of this need: _____

Name of Health Care Provider: _____ Date: _____
Please print name

Signature of Health Care Provider: _____ Telephone Number: _____

Type of Practice: _____

Address: _____
_____

To be completed by the employee needing FMLA 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 : _____

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

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

[3] 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.

[4] A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.