



Medical Certification Form

For Family Medical Leave under the Family and Medical Leave Act for 1993

TO BE COMPLETED BY THE EMPLOYEE:

EMPLOYEE NAME

G Number

PATIENT NAME (if different from employee)

G _ _ _ _ _
RELATIONSHIP TO EMPLOYEE

Complete this section if the Family Medical Leave is to care for the family member. State the care you will provide and an estimate of the periods during which the 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

TO BE COMPLETED BY HEALTH CARE PROVIDER

DATE OF EXAMINATION

FIRST DATE OF DISABILITY(OUT OF WORK)

EXPECTED DURATION OF INCAPACITY

EXPECTED DATE OF RETURN TO WORK

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

Does the patient's condition qualify as a serious health condition under any of the categories described below? If so, please check the applicable category.

- Hospital Care** - Inpatient care in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with such inpatient care.
- 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:
 - Treatment 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
 - Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment 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:
 - (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).
- 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 (e.g., Alzheimer's, severe stroke, terminal stages of disease). The patient must be under the continuing supervision of a health care provider.
- Multiple Treatments (Non-chronic Conditions)** - Any period of absence to receive multiple treatments 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 (e.g., chemotherapy, physical therapy, dialysis)

Health Care Provider – Please complete next page—▶

HEALTH CARE PROVIDER PLEASE COMPLETE IF THE EMPLOYEE IS THE PATIENT

State the approximate date the condition commenced and the probable duration of the condition (also the probable duration of the patient's present incapacity if different):

Will it be necessary for the employee to work intermittently or to work on a less than full schedule as a result of the condition or treatment?

- Yes
- No

If yes, give the probable duration: _____

If the condition is chronic or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity:

If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments: _____

If a regimen of continuing treatment is required, provide a general description of such regimen (e.g., prescription drugs, physical therapy), including an estimate of the probable number of and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

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:



Is the employee unable to perform work of any kind?

- Yes
- No

If able to perform some work, is the employee unable to perform the **essential functions of the employee's job** (the employee or Mason can supply you with information about the essential job functions)?

- Yes
- No

If yes, please list the essential functions the employee is unable to perform:

HEALTH CARE PROVIDER PLEASE COMPLETE IF THE PATIENT IS THE EMPLOYEE'S FAMILY MEMBER

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, safety, or 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

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

I certify that I have completed the Health Care Provider Section of this form.

Print Name of the Health care Provider:

Health Care Provider Signature:

Date _____