Return to: Employee Service Center/WHQMW
Case #: ________________

Fax number: 1-847-700-3084
Date FMLA Leave requested: ______________

California Employee Serious Health Condition Certification Form

(Family and Medical Leave Act of 1993)

Instructions for the employee: Complete Sections A and F and have your health care provider complete Sections B, C, D, and E of this form and return it within 15 calendar days directly to the Employee Service Center (ESC). Do not return this form to your Supervisor/Manager. If you fail to provide the completed certification form within 15 calendar days, your leave may be delayed and any absences prior to your submission of the completed form will not be counted as FMLA Leave and will be counted against your dependability record.

Section A Employee information - To be completed by employee

Please check one: ☐ New Certification ☐ Recertification

Employee name: ______________________________ Employee ID: ____________ Shift: ____________

Home phone: ______________ Home mailing address: ________________________________

Job title: ______________________________ Work location: ____________ Work phone: ____________

Supervisor name: ____ Supervisor phone: ______________

Section B Serious health condition certification - To be completed by health care provider

Instructions for the health care provider: Please give a written response to each section of this certification form. Failure to complete each section may delay the employee's leave.

Categories of a Serious Health Condition under the Family Medical Leave Policy

Please check the applicable categories below:

☐ **1. Hospital Care:** Inpatient care (an overnight stay in a hospital, hospice, or residential medical facility) including any period of incapacity for subsequent treatment. "Incapacity" for the purpose of FMLA is defined to mean an inability to work, attend school, or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery there from.

☐ **2. Absence Plus Treatment:** a period of incapacity (inability to work or perform other regular daily activities) for 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 by a provider of health care services (e.g., physical therapist) under orders of, or on referral by a health care provider, including 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,

or

☐ Treatment by a health care provider at least one time which results in a regimen of continuing treatment (course of prescription medication or therapy requiring special equipment) under the supervision of the health care provider.

Categories of a Serious Health Condition under the Family Medical Leave Policy
(Continued from previous page)

❒ **3. Pregnancy:** Any period of incapacity due to pregnancy or for prenatal care.

❒ **4. Chronic Conditions Requiring Treatment:** 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 (this may include asthma, diabetes, epilepsy, etc.).

❒ **5. Permanent or 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 (this may include Alzheimer's, severe stroke, or terminal stages of disease). The patient must be under the continuing supervision of a health care provider, but need not be receiving active treatment by the provider.

❒ **6. Multiple Treatments (Non-Chronic Conditions):** any period of absence to receive multiple treatments by a health care provider, either for restorative surgery after accident or 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. This may include cancer (chemotherapy or radiation), severe arthritis (physical therapy), or kidney disease (dialysis).

Section C Parameters of FMLA Leave – To be completed by health care provider

Please provide best estimate based on patient's history:

1. General questions

State the date you began treating the employee for the condition: ____/____/______
(mm/dd/yyyy)

State the approximate date the condition commenced: ____/____/______
(mm/dd/yyyy)

State the probable duration of the condition: ____/____/______
(mm/dd/yyyy)

2. Type of leave needed for incapacity due to the condition

What type of leave the employee will need for incapacity due to the condition (please check all that apply):

Block/continuous leave	Yes_____	No_____	(If yes, complete section 2.a. below)
Reduced schedule leave	Yes_____	No_____	(If yes, complete section 2.b. below)
Unforeseeable Intermittent Leave	Yes_____	No_____	(If yes, complete 2.c. below)

2.a. - Block/Continuous Leave

State the date the incapacity causing the need for leave commenced (mm/dd/yyyy):________________

State how long the employee is expected to be incapacitated and unable to work:________________

Will the employee be hospitalized or receiving in-patient care? Yes_____ No_____

If yes, how long? ____

Parameters of FMLA Leave - To be completed by health care provider
(Continued from previous page)

2.b. - Reduced Schedule Leave
State the timeframe during which the employee will need to have a reduced schedule:______________
____

State the parameters of the reduced schedule the employee can work (i.e. – how many hours per day and/or days per week is the employee able to work:________________________________
____

2.c. - Unforeseeable Intermittent Leave
State the time frame during which the employee will need to take unforeseeable intermittent leave due to incapacity. Start date: ____/____/_____ (mm/dd/yyyy) End date: ____/____/_____ (mm/dd/yyyy)

Provide an estimate of how often the employee will need to take intermittent leave and the duration of each episode of intermittent incapacity:

Duration: _____ ☐ Hours ☐ Days

Frequency: _____ times per ☐ Week ☐ Month ☐ Year

Please note: Failure to provide an estimate of the timeframe, frequency, and duration per year will result in the delay of FMLA approval.

3. Treatment
State the actual dates of treatment for the condition (mm/dd/yyyy): ______________________
____

State the actual dates of anticipated or scheduled treatment (mm/dd/yyyy):
____

State the time frame during which the employee will need to receive treatment due to incapacity:
Start date: ____/____/_____ (mm/dd/yyyy) End date: ____/____/_____ (mm/dd/yyyy)

Will routine office visits be required for the condition? Yes_____ No_____
If yes, how often? _____ Visits per ☐ Week ☐ Month ☐ Year

Will treatment other than routine office visits be required for the condition? Yes_____ No_____
If yes, how often? _____ Visits per ☐ Day ☐ Week ☐ Month ☐ Year
If yes, will the employee be incapacitated as a result of these treatments and be unable to work?
Yes_____ No_____
If yes, how long will the employee be incapacitated? _______ ☐ Hours ☐ Days ☐ Weeks

Please provide a general description of the treatment regimen (e.g. prescription drugs, physical therapy, etc.) for the intermittent, continuous, or block FMLA Leave.
____
____
____
____

Section D Employee's work status while affected by the serious health condition – To be completed by health care provider

When the employee is incapacitated, is the employee unable to perform work of any kind? Yes___ No___
If yes, please list the work functions the employee is unable to perform (e.g. sitting, lifting, typing, etc.)

____

____

____

Section E Certifying signature – To be completed by health care provider

Signature of health care provider/title (This signature certifies that this form was completed by the health care provider)	Date
Print or type name of health care provider	Type of practice
Address	Telephone number Fax number
Health care provider's office hours (To be completed by health care provider)	Appointment hours

Section F Certifying signature – To be completed by employee

Employee signature (This signature certifies that this form was completed by the health care provider)	Date