Return to: Employee Service Center/WHQMW **Fax number: 1-847-700-3084**

Case #: _____ **Date FMLA Leave requested:** _____

California Family Member Serious Health Condition Certification Form

(Family and Medical Leave Act of 1993)

Instructions for the employee: Complete Section A and B and sign and date in Section F. Then, have your health care provider complete Sections C, D, E, and F of this form and return within 15 calendar days from date of request directly to the Employee Service Center. If you fail to provide the completed certification form within the allotted time, leave may be denied or the start of your leave may be delayed and any absences prior to your submission of the completed form will not be counted as leave under the provisions of the Family and Medical Leave Act (FMLA) 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: _____

Name of family member: _____

Relationship to employee: ☐ Spouse ☐ Child (age of child_____ (mm/dd/yyyy)) ☐ Parent

Section B Leave requested – To be completed by employee

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 on a reduced hours basis:_____

_____

_____

_____

Will it be necessary to be off work for a continuous period of time? ☐ Yes ☐ No

If yes, specify start date: ____/___/_____ (mm/dd/yyyy) End date: ____/___/_____ (mm/dd/yyyy)

Will it be necessary to be off work intermittently? ☐ Yes ☐ No

If yes, specify start date: ____/___/_____ (mm/dd/yyyy) End date: ____/___/_____ (mm/dd/yyyy)

If yes, specify frequency: _____ times per ☐ Week ☐ Month ☐ Year. For how long (duration)? ___

☐ Hours ___ ☐ Days

Will it be necessary to work a reduced schedule (less than a full schedule)? ☐ Yes ☐ No

If yes, specify start date: ____/___/_____ (mm/dd/yyyy) End date: ____/___/_____ (mm/dd/yyyy)

If yes, how many hours _____ per ☐ Day ☐ Week can you work? Or, how many days_____ per week can you work?

Employee Signature _____ Date: ____/____/_____

Section C Serious health condition – To be completed by health care provider

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

Categories of a Serious Health Condition under FMLA

Please check the applicable categories below:

❒ **1. Hospital Care:** Inpatient care (an overnight stay in a hospital, hospice, or residential medical care 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 that results in a regimen of continuing treatment (course of prescription medication or therapy requiring special equipment) 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 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).

❒ **7. None of the Above.** Please explain:_____

_____

Section D Requirements to care for family member – To be completed by health care provider

1. State the approximate date the patient's condition began: ____/____/_____
(mm/dd/yyyy)

State the probable duration of the patient's condition: _____

State whether the patient is currently incapacitated? ❒ Yes ❒ No
If yes, state the patient's probable duration of incapacity: _____

State the approximate time frame during which the employee will need to take unforeseeable intermittent leave due to patient's incapacity: Start date: ____/____/_____ End date: ____/____/_____
(mm/dd/yyyy) (mm/dd/yyyy)

If the employee will need to take intermittent leave, provide an estimate of:
Duration: _____ ❒ Hours ❒ Days
Frequency: _____ times per ❒ Week ❒ Month ❒ Year

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

2. Treatment: If treatment will be required for the condition:

State the actual dates of treatment (mm/dd/yyyy): _____

_____

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

_____

Provide a general description of such regimen (e.g., prescription drugs, physical therapy, etc.): _____

_____

_____

_____

How often will the patient need treatments that will require office visits? _____ ❒ Days ❒ Weeks ❒ Months ❒ Years
State the time frame during which the employee will need to receive treatment due to incapacity from Start date: ____/___/_____ End date: ____/____/_____.
(mm/dd/yyyy) (mm/dd/yyyy)

Will the patient be incapacitated as a result of such treatments? ❒ Yes ❒ No
If yes, specify _____ ❒ Hours ❒ Days per treatment.

Will any of these treatments be provided by another Health Care Provider? ❒ Yes ❒ No
If yes, how often _____ ❒ Hours _____ ❒ Days per ❒ Week ❒ Month ❒ Year

Section E To be completed by health care provider only if the patient is the employee's child and is age 18 or older

Does the patient have a mental or physical disability (defined as a physical or mental impairment that substantially limits one or more major life activities)? ❒ Yes ❒ No

If yes, please describe the disability: _____

_____

_____

_____

State the date the disability began: ____/____/_____
(mm/dd/yyyy)

State the anticipated duration of the disability:_____

Please check the activities the patient requires active assistance or supervision with:

Activities of Daily Living

❒ Yes ❒ No Grooming
❒ Yes ❒ No Hygiene
❒ Yes ❒ No Bathing
❒ Yes ❒ No Dressing
❒ Yes ❒ No Eating
❒ Yes ❒ No Other: _____

Instrumental Activities of Daily Living

❒ Yes ❒ No Cooking
❒ Yes ❒ No Cleaning
❒ Yes ❒ No Shopping
❒ Yes ❒ No Taking public transportation
❒ Yes ❒ No Maintaining a residence
❒ Yes ❒ No Using a telephone
❒ Yes ❒ No Going to a Post Office
❒ Yes ❒ No Other: _____

Section F Certifying signatures (no signature stamps please)

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:

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