Livingstone College
Office of Human Resources

Health Certification Form

Employee's Serious Health Condition

Employee's Name:	**Hire Date:**

Health Care Provider Instructions:
Please answer fully and completely all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Please limit your responses to the condition for which the employee is seeking certification. Please be sure to sign the form on the last page.

Provider's name: _____

Provider's address:_____

Type of practice / Medical specialty: _____

Telephone: (_____)_____ Fax:(_____)_____

Part A. Medical Facts

1. Attached to this form is a definition of "serious health condition." Please review this list and check which category applies to your patient's condition, if any.

   (1)_____ (2) _____ (3)_____ (4) _____ (5) _____ (6)_____, or None Apply _____

2. Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria for one of the above categories. If the condition is pregnancy, please provide the expected delivery date.

   _____

   _____

   _____

3. Approximate date condition commenced: _____ Probable duration of condition: _____

   Date(s) you treated the employee for condition:

   _____

4. 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? _____Yes _____No If yes, please give the probable duration.

   _____

   _____

5. If the condition is a chronic condition, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity.

6. Was the employee admitted for an overnight stay in a hospital, hospice, or residential medical care facility? _____No _____Yes If yes, date of admission:_____

7. Was medication, other than over-the counter medication, prescribed? _____No _____Yes

8. Was the employee referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

   _____No _____Yes If yes, please state the nature of such treatment and expected duration of treatment:

   _____

9. Please use the job description provided by the employee attached to this form to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions. Is the employee unable to perform any of his/her job functions due to the condition: ____ No ____ Yes. If so, identify the job functions the employee is unable to perform:_____

10. Please describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regiment of continuing treatment such as the use of specialized equipment):

    _____

    _____

Part B. Amount of Leave Needed

11. Will the employee be incapacitated for a single continuous period of time, including any time for treatment and recovery? _____No _____Yes

    Please estimate the beginning and ending dates for the period of incapacity: _____

12. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? _____No _____Yes

    If so, are the treatments or the reduced number of hours of work medically necessary? _____No _____Yes

    Please estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment including any recovery period:

    _____

    _____

Please estimate the part-time or reduced work schedule the employee needs, if any:

_____hour(s) per day; _____days per week from _____ through _____

13. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? _____No _____Yes

    Is it medically necessary for the employee to be absent from work during the flare-ups? _____No _____Yes

    If yes, please explain:_____

    _____

    Based upon the employee's medical history and your knowledge of the medical condition, please estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g,. 1 episode every 3 months lasting 1-2 days):

    Frequency:_____ times per _____week(s) _____ month(s)

    Duration:_____ hours or _____ day(s) per episode

    Additional Information: (Please identify the question number with your additional answer.)

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Health Care Provider **Date**

Definition of a Serious Health Condition

A **"Serious Health Condition"** means an illness, injury impairment, or physical or mental condition that involves one of the following:

1. **Hospital Care**
   Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity[1] 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 there from) 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), and kidney disease (dialysis).

[1] "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 therefore, or recovery there from.

[2] 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.

[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, and other similar activities that can be initiated without a visit o a health care provider.