Livingstone College
Office of Human Resources

# Health Certification Form

## Family Member's Serious Health Condition

| Employee's Name: | Patient's Name: |
|---|---|

**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. Approximate date condition commenced: _______________ Probable duration of condition: ____________

3. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ______No ____Yes If yes, date of admission:_______________________________________________

4. Was medication, other than over-the counter medication, prescribed? ______No ______Yes

5. Will the patient need to have treatment visits at least twice per year due to the condition? ____No ____Yes

6. Was the patient 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:

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

8. If the medical condition pregnancy? ______No _______Yes If yes, expected delivery date:____________

9. 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

When answering the following questions, please keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care.

1. Will the patient 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: _________________________

   During this time, will the patient need care? ______No _______Yes

   Please explain the care needed by the patient and why such care is medically necessary.

   ____________________________________________________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________

2. Will the patient require follow-up treatments, including any time for recovery? ______No _____Yes

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

   ____________________________________________________________________________
   ________________________________________________________________________

3. Will the patient require care on an intermittent basis, including any time for recovery? ____No ____ Yes

   If yes, please explain the care needed:

   ___________________________________________________________________________

   Please estimate the hours the patient needs care on an intermittent basis, if any:

   _________ hour(s) per day; ______day per week from ___________________to____________________

4. Please identify any additional information you feel is important to understand about the care required for your patient.____________________________________________________________________

________________________________________ ___________________________________
**Signature of Health Care Provider** **Date**

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## 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.