**CERTIFICATION OF HEALTH CARE PROVIDER**
(Family and Medical Leave Act of 1993)

1. Employee's Name

2. Patient's Name (if different from employee):

3. The attached sheet describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition[1] qualify under any of the categories described? If so, please check the applicable category:

   (1)____(2)____(3)____(4)____(5)____(6)____ or None ____

4. Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

5. (a) State the approximate date the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present incapacity[2] if different:

   (b) Will it be necessary for the employee to take work only intermittently or to work less than a full schedule as a result of the condition (including for treatment described in Item 6 below)? If yes, give the probable duration.

   (c) If the condition is a chronic condition (condition #4) or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity:

6. (a) If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments: _____. If the patient will be absent from work or other daily activities because of treatment on an intermittent or part-time basis, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment, if known, and period required for recovery, if any:

(b) 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:

(c) If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

7. (a) If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind?

(b) If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job? _____. If yes, please list the essential functions the employee is unable to perform?

(c) If neither (a) or (b) applies, is it necessary for the employee to be absent from work for treatment?

8. (a) 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 or safety, or for transportation?

(b) If no, would the employee's presence provide psychological comfort to benefit the patient or assist in the patient's recovery?

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

_____ _____

(Signature of Health Care Provider (Type of Practice)

_____ _____

(Address of Health Care Provider) (Telephone number)

*To be completed by the employee needing family leave to care for a family member:*

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 if it will be necessary for you to work less than a full schedule:

_____ _____

(Employee signature) (Date)

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 care facility, including any period of incapacity 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:

   (a) Treatment[3] two or more times by a health care provider, by a nurse or physician's assistant under the 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
   (b) Treatment by a health care provider on at least one occasion which results in a regiment of continuing treatment[4] under the supervision of a health care provider.

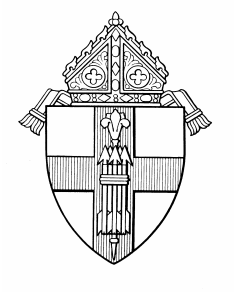
3. Pregnancy: any period of incapacity due to pregnancy or for prenatal care.

4. Chronic Conditions Requiring Treatment: A chronic condition which:

   (a) Requires periodic visits for treatment by a health care provider or by a nurse or physician's assistant under the direct supervision of a health care provider;
   (b) Continues over an extended period of time (including recurring episodes of a single underlying condition); and
   (c) 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 therefrom) 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), kidney disease (dialysis), etc.



**REQUEST FOR FAMILY/MEDICAL LEAVE**

**DATE:** _____

**FROM:** _____

**DEPARTMENT:** _____

This is to request a Family and Medical Leave of Absence for the following reason (*check one)*:

- ❑ The birth of a child in order to take care of the child (leave must be taken within 12 months of the birth and child must live with employee).

- ❑ The adoption or foster care placement of a child in order to care for the child (leave must take place within 12 months of the placement in the employee's home).

- ❑ A serious health condition affecting my [ ] spouse, [ ] child, [ ] parent, because the ill person is not capable of self-care and I am needed for such care (see attached Certification of Health Care Provider.

- ❑ My serious health condition which results in my inability to perform my job (see attached Certification of Health Care Provider.

I wish to commence this leave of absence on _____

I anticipate that this leave will end on _____

_____
Employee signature

Approved by: _____

Date approved: _____