

NATIONAL POSTAL MAIL HANDLERS UNION

Family Medical Leave Act of 1993 – FMLA

Medical Certification of a Serious Health Condition

Health Care Provider: The information sought on this form, relates only to the condition for which the employee is taking FMLA leave. This information is needed for the employee to receive job protection for leave due a serious health condition. PLEASE FILL OUT THE ENTIRE FORM.

Employee Name (Print)

1. Patient's name: _____
Relationship to employee: Self (omit question #6) Child Spouse Parent
2. Description of serious health condition: The back of this form describes what is meant by a "serious health condition" under FMLA. Does the patient's condition qualify under any of the categories described? If so, please check the box(es) below
 1 - Hospitalized 2 - Absence + treatment 3 - Pregnancy 4 - Chronic 5 - Permanent/long-term 6 - Multiple treatment None of these
3. Medical facts: Please describe briefly the **medical facts** which fit the category checked above, no need for a specific diagnosis.

4. **Duration of condition and incapacity**
 - a. Date condition began: _____ Probable Duration of the condition: _____
"Incapacity," for purposes of the 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.
 - b. If the condition is a chronic condition (condition #4) or pregnancy(#3), state whether the patient is;
 - i. **Presently incapacitated:** Yes No
 - ii. If YES, the likely **duration of present incapacity:** _____
 - iii. If NO, the likely **frequency and duration of subsequent episodes of incapacity:** _____
 - c. Will it be necessary for the employee to **take time off from work only intermittently or to work on a less than full schedule** as a result of the condition (including for treatment described in Item 5 below)? Yes No If YES, recommend schedule: _____
5. If additional treatments will be required for the condition, please describe: *the nature of such additional treatments or continuing regimen of treatment under your supervision (e.g., prescription drugs, physical therapy requiring special equipment); the probable number of such treatments; the length of the employee's required absence for the treatments; and the actual or estimated dates of the treatments, if known.*

6. **IF FMLA Certification is for a FAMILY MEMBER** – Does the patient need the employee to care for; *if applicable*
 - a. Does the patient require basic assistance (medical, hygiene, nutritional needs, safety or transportation)? Yes No
 - b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? Yes No
 - c. Will it be necessary for the employee to take time off work intermittently or to work on a less than full schedule as a result of the patient's condition and/or treatments? Yes NoIf yes to any of the above, give the probable frequency and duration of this need: _____

Health Care Provider Name: _____ Type of Practice: _____

Phone: _____ Address: _____

Signature: _____ Date: _____

Employee: Keep a copy for your records, provide a copy to the NPMHU, and Return the completed form to the appropriate Postal Service Supervisor.

"Serious Health Condition"

Definition under Family and Medical Leave Act of 1993

A "serious health condition" is defined in the FMLA regulations as any illness, injury, impairment or physical or mental condition that involves one or more of the following:

1. **Hospital care:**

This means **inpatient care** (that is, an overnight stay or longer) in a hospital, hospice or residential medical 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 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
- b. **Treatment** by a health care provider on **at least one occasion** which results in a **regimen of continuing treatment** 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

- a. 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;
- 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:**

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), kidney disease (dialysis).

Treatment 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.

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 to a health care provider.

"Incapacity," for purposes of the 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.