

**Family and Medical Leave Act
Serious Health Condition Certification**

**STATE SYSTEM OF HIGHER EDUCATION
Family Member Form**

FOR THE EMPLOYER TO COMPLETE:	
Employee	Employee Number
Agency	Work Location

FOR THE EMPLOYEE TO COMPLETE:		
Family Member / Patient Name	Family Member Relationship to Employee	Family Member Age
Does the family member require assistance for basic medical, hygienic, nutritional, safety, or transportation needs? <input type="checkbox"/> Yes <input type="checkbox"/> No		
How will the leave be used (intermittently, as needed, on a specific schedule, etc.)?		
What type of care will you be providing while using the leave (be specific)?		
Employee Signature	Date	

FOR THE HEALTH CARE PROVIDER TO COMPLETE:	
1. When did the condition commence?	
2. When did the incapacity commence?	
3. Is the patient presently incapacitated? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, when did the incapacity cease? <input type="text"/>	
A. If yes, does the patient require assistance for basic medical, hygienic, nutritional, safety, or transportation needs? <input type="checkbox"/> Yes <input type="checkbox"/> No	
B. If yes, what are the physical or mental impairments that require the employee to be absent from work to attend to the patient?	
4. Has a regimen of continuing treatment been prescribed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
A. If yes, please describe the type of treatment, i.e. physical therapy, prescription drugs, etc.	
B. If yes, has regimen been completed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when was the regimen completed? <input type="text"/>	
5. Are additional treatments required for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	
A. If yes, where will the treatments be provided? If not in your office, will you remain involved with the treatment?	
B. If yes and if known, what are the dates of the next several treatments? How long will treatments continue?	

<p>6. Will it be necessary or possible for the employee to care for the patient intermittently or part-time? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		
<p>A. If yes, what is the schedule?</p>		
<p>B. If yes, what is the probable duration of such intermittent or part-time care?</p>		
<p>7. Upon recovery, is it likely that episodes of incapacity will arise? If yes, how frequently? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		
<p>A "serious health condition" is an illness, injury, impairment, or physical or mental condition. Please check all blocks that apply to the patient's serious health condition.</p> <p><input type="checkbox"/> Hospital Care. Inpatient (not outpatient) care 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.</p> <p><input type="checkbox"/> 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 involves: (1) 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 (ex. 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 under the supervision of a health care provider. A regimen of continuing treatment does not include taking over-the-counter medications, bed-rest, drinking fluids, exercise, or other similar activities that could be initiated without a visit to a health care provider.</p> <p><input type="checkbox"/> Pregnancy. Any period of incapacity due to pregnancy or for prenatal care.</p> <p><input type="checkbox"/> 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 the 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 (asthma, diabetes, epilepsy, etc.)</p> <p><input type="checkbox"/> 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, severe stroke, or the terminal stages of a disease.</p> <p><input type="checkbox"/> 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).</p> <p><input type="checkbox"/> None of the above.</p>		
<p>Describe the medical facts and how they support the above selected serious health condition category.</p>		
<p>Signature of Health Care Provider</p>	<p>Type of Practice</p>	<p>Date</p>
<p>Health Care Provider Name and Address (please print)</p>		<p>Health Care Provider Telephone Number</p>