

## Health Care Provider Statement

1. Employee's Name: \_\_\_\_\_

2. Patient's Name (if different than 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<sup>7</sup> qualify under any of the categories described? If so, please check the applicable category.

(1) \_\_\_\_\_ (2) \_\_\_\_\_ (3) \_\_\_\_\_ (4) \_\_\_\_\_ (5) \_\_\_\_\_ (6) \_\_\_\_\_  
None of the above \_\_\_\_\_

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:

5a. 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<sup>8</sup> if different):

5b. 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 (including treatment described in item 6 below):  
If yes, give the probable duration:

5c. 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.

6a. If additional treatments will be required for the condition, provide an estimate of the probably number of such treatments.

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

6b. 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.

6c. 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).

7a. 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? \_\_\_\_\_

<sup>7</sup> Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

<sup>8</sup> "Incapacity," for purpose of FMLA, is defined to mean inability to work, attend schools or perform other regular daily activities due to the serious health condition, treatment therefore or recovery therefrom.

7b. 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 (see attached position description)? \_\_\_\_\_ If yes, please list the essential functions the employee is unable to perform:

7c. If neither 7a. nor 7b. applies, is it necessary for the employee to be absent from work for treatment? \_\_\_\_\_

8a. 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? \_\_\_\_\_

8b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? \_\_\_\_\_

8c. If the patient will need care only intermittently or on a part-time basis, please indicate the probably duration of this need:

\_\_\_\_\_  
(Signature of Health-care Provider)

\_\_\_\_\_  
(Type of Practice)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Telephone Number)

**“Serious Health Condition”** – Under federal law means an illness, injury, impairment or physical or mental condition that involves:

1. Any period of incapacity or treatment in connection with or consequent to inpatient care (i.e., an overnight stay) in a hospital, hospice or residential medical care facility;
2. Any period of incapacity requiring absence from work, school or other regular daily activities, of more than three (3) calendar days, that also involves continuing treatment by (or under the supervision of ) a health-care provider; or
3. Continuing treatment by (under the supervision of) a health-care provider for a chronic or long-term health condition that is incurable or so serious that, if not treated, would likely result in a period of incapacity of more than three (3) calendar days; or for prenatal care.

An employee is unable to perform the function of the position when the health-care provider finds that the employee is unable to work at all or is unable to perform any of the essential functions of the employee’s position within the meaning of the Americans with Disabilities Act and federal regulations. BMCC has the option, in requiring medical verification from a health-care provider, to provide a statement of the essential functions of the employee’s position for the provider to review.

A “serious health condition” under state law means an illness, injury, impairment or physical or mental condition of an employee or family member that:

1. Requires inpatient care in a hospital, hospice or residential medical care facility such as a nursing home. When a family member resides in a long-term residential care facility, leave shall apply only to:
  - a. Transition periods spent moving the family member from one home or facility to another, including time to make arrangements for such transitions;
  - b. Transportation or other assistance required for a family member to obtain care from a physician;
  - c. Serious health conditions as described in this regulation.
2. The treating health-care provider judges to pose an imminent danger of death, or that is terminal in prognosis with a reasonable possibility of death in the near future;
3. Requires constant or continuing care such as home care administered by a health-care professional;

4. Involves a period of incapacity. Incapacity is the inability to perform at least one essential job function, or to attend school or perform regular daily activities for more than three consecutive calendar days and any subsequent required treatment or recovery period relating to the same condition. This incapacity must involve:
  - a. Two or more treatments by a health-care provider;
  - b. One treatment plus a regimen of continuing care; or
  - c. Any period of incapacity or treatment for a chronic serious health condition that requires periodic visits for treatment by a health-care provider, continues over an extended period of time and may cause episodic rather than a continuing period of incapacity such as asthma, diabetes or epilepsy.
5. Involves permanent or long-term incapacity due to a condition for which treatment may not be effective, such as Alzheimer's disease, a severe stroke or terminal stages of a disease;
6. Involves multiple treatments for restorative surgery or for a condition such as chemotherapy for cancer, physical therapy for arthritis or dialysis for kidney disease that if not treated would likely result in incapacity or more than three (3) days; or
7. Involves any period of disability of a female due to pregnancy or childbirth or period of absence for prenatal care.