CERTIFICATION OF QUALIFIED HEALTH PROVIDER

FAMILY MEMBER'S SERIOUS HEALTH CONDITION

TO BE COMPLETED BY THE EMPLOYEE REQUESTING LEAVE ONLY

EMPLOYEE NAME: _____

FAMILY MEMBER'S NAME: _____

RELATIONSHIP TO EMPLOYEE: _____

Describe the care you will be providing to your family member and estimate the period of time in which this care will be provided, including a schedule of intermittent leave or if a reduced schedule is to be taken:

_____

_____

_____

_____

EMPLOYEE SIGNATURE: _____ **DATE:** _____

TO BE COMPLETED BY THE TREATING QUALIFIED HEALTH PROVIDER ONLY

1. Patient's Name: _____

2. Does the patient have a "catastrophic or serious illness, injury or other medical condition" as described on page 3 of this form? If the patient's condition qualifies under any of these categories, please circle the applicable number:

   (1) (2) (3) (4) (5) (6)

NOTE: THE QUALIFIED HEALTH PROVIDER IS NOT TO DISCLOSE THE UNDERLYING DIAGNOSIS.

3. Date medical condition or need for treatment commenced: _____

4. Probable duration of medical condition or need for treatment: _____
   Start Date: _____ End Date: _____

5. Is inpatient hospitalization of the patient required? **YES** **NO**

6. Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation? **YES** **NO**

7. After review of the employee's signed statement above, does the patient's condition warrant the participation of the employee? (This participation may include psychological comfort and/or arranging third-party care for the patient.) **YES** **NO**

CONTINUOUS LEAVE

8. Beginning date that the patient will need care: _____

9. Date the continuous leave for care of the patient will end: _____

INTERMITTENT LEAVE

10. Date intermittent leave is to begin: _____

11. Date intermittent leave is to end: _____

12. Is it medically necessary for the employee to be off work on an intermittent basis or on a reduced work schedule in order to care for the patient with a serious health condition?
YES NO

If **YES**, please estimate the frequency/number of doctor's visits and/or estimated duration of medical treatment, either by the health care provider or another provider of health care services.

Frequency: _____ times per _____ week(s) OR _____per month(s)

Duration: _____ hour(s) OR _____ day(s) per appointment/treatment

13. Will the patient's condition cause episodic flare-ups periodically requiring the employee to be off work on an intermittent basis or reduced work schedule to participate in the patient's treatment or care? **YES NO**

14. Based on the patient's medical history, please estimate the frequency and duration that the employee may need to be away from work (due to flare- ups/episodes, doctor's visits, etc.) for the care of the patient (e.g. 1 episode every 3 months lasting 1-2 days)

Frequency: _____ times per _____ week(s) OR _____ per month(s)

Duration: _____ hour(s) per day OR _____ hour(s) per episode

HEALTH PROVIDER NAME (printed): **SIGNATURE:**

_____ _____

SPECIALTY: **DATE:** **ADDRESS:**

_____ _____ _____

_____

Catastrophic or serious illness, injury or other medical condition

A catastrophic or serious illness, injury or other medical condition, for this program, is defined as an acute or prolonged illness, injury, or other medical condition resulting in the employee's inability to work, either due to his/her own injury, illness or medical condition, or that of a family member, requiring that the employee take time off work to care for the seriously ill or injured family member.

1. **Hospital Care**
   Inpatient 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. A person is considered an "inpatient" when a health care facility formally admits him or her to the facility with the expectation that he or she will remain at least overnight and occupy a bed, even if it later develops that such person can be discharged or transferred to another facility and does not actually remain overnight.

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 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 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), or kidney disease (dialysis).