

St. Louis County
FMLA Medical Certification Form

Name _____ Department _____

EIN # _____ Work Phone _____ Home Phone _____

Patient's name if not the employee: _____

Information about the serious health condition:

Review the descriptions of serious health conditions which follow and check the box of that which applies to the patient:

- Hospital Care.** Inpatient care (overnight stay) 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.
- 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 treatment (1) two or more times by a health care provider, nurse or physician's assistant under direct supervisor 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 (2) 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.
- Pregnancy.** Any period of incapacity due to pregnancy or for prenatal care.
- Chronic Conditions Requiring Treatment.** A chronic condition which (1) requires periodic visits for treatment by a health care provider or by a nurse or physician's assistant under direct supervision of the health care provider; (2) continues over an extended period of time (including recurring episodes of a single underlying condition); (3) may cause episodic rather than a continuing period of incapacity (e.g. asthma, diabetes, epilepsy, etc.)
- 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 terminal stages of a disease.
- 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 for 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).

Tell us how the medical facts meet the criteria for the category you checked above. Provide only information which pertains to the condition of the patient which necessitates the absence from work of the employee (whether or not the employee is the patient): _____

Date the condition began or will begin _____ Anticipated Date of Return _____

Treatments for the condition: List approximate number and dates or timing of additional treatments necessary to treat the condition: _____

What is the regimen of continuing treatment which you are requiring for the patient? _____

Are additional treatments necessary ? Yes No

If yes, what will be the nature of any treatments provided by another provider of health services (such as physical therapy)? _____

Requirement for employee's absence from work: (consider these questions whether the absence is for the employee's own condition or the condition of the employee's family member)

Can the employee work full time? Yes No

If the employee will need a reduced work schedule, what will the recommended schedule be? _____

For how long? _____

Will the employee need to be absent intermittently because of the condition? Yes No

If yes, under what circumstances would the employee need to be absent? _____

Will the treatments identified above require the employee's absence from work ? Yes No

If yes, describe: _____

If the condition is chronic or involves pregnancy, is the patient presently incapacitated? Yes No

If yes, for how long? _____

Complete these questions if the patient is the employee:

If the medical condition requires the employee's absence from work (including absence due to pregnancy or a chronic condition), is the employee able to perform work of any kind? Yes No

If yes, list any one or more of the essential functions of the employee's job (refer to the attached job description and discuss the essential job functions with the employee) which can be performed: _____

Complete these questions if the patient is a family member of the employee:

Is the employee required to be present with a family member with serious health condition for assistance in basic medical or personal needs or safety or for transportation? Yes No

If no, is the employee's presence beneficial for providing psychological comfort to the patient or assisting in the patient's recovery? Yes No

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 _____

PRINT NAME HERE _____ Date _____

Type of practice _____ Phone # _____

TO BE COMPLETED BY 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 take intermittently or if it will be necessary for you to work less than a full schedule:

