Print Form

Allegany County Government
Certification of Health Care Provider

Certification of Health Care Provider
(Family and Medical Leave Act of 1993)

Return to:
Allegany County
Human Resources & Personnel Services
701 Kelly Road, Suite 412
Cumberland, Maryland 21502

In Accordance With:
U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

1. Employee's Name: _____

2. Patient's Name: _____

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 [1] qualify under any of the categories described? If so, please check the applicable category.

☐ (1) ☐ (2) ☐ (3) ☐ (4) ☐ (5) ☐ 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 selected categories:

5. 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** [2] if different):

b. Will it be necessary for the employee to take work **only intermittently or to work on a less than full schedule** as a result of the condition (including for treatment described below in item 6)? If yes, give the probable duration.

c. If the condition is a **chronic condition** (condition #4) or **pregnancy**, state whether the patient is presently incapacitated[2]and the likely duration and frequency of **episodes of incapacity** [2]:

6. If additional **treatments** will be required for the condition, provide an estimate of the probable number of such treatments:

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

b. 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:

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c. 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):

7. 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?

b. 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 as outlined on the attached form? If yes, please list the essential functions the employee is unable to perform:

c. If neither a. or b. applies, is it necessary for the employee to be absent from work for treatment?

8. 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 or assist in the patient's recovery?

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

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

9. Is there anything about the chronic condition that would cause it to flare up on Fridays or Mondays?

Signature of Health Care Provider

Type of Practice

Address

Telephone Number

To be completed by the employee needing the 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 of leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

Employee Signature

Date

1 Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.

2 "Incapacity" for purposes of FMLA, is defined to mean inability to work, attend school, or perform other regular daily activities due to the serious health condition, treatment thereof, or there from.

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SERIOUS HEALTH CONDITIONS BY CATEGORY
AS IDENTIFIED BY THE FAMILY AND MEDICAL LEAVE ACT OF 1993

1. A health condition (including treatment thereof, or recovery therefrom) lasting more than three consecutive days, and any subsequent treatment or period of incapacity relating to the same condition, that also includes:
   - treatment two or more times by or under the supervision of a health care provider; or
   - one treatment by a health care provider with a continuing regimen of treatment

2. Pregnancy or prenatal care. A visit to the health care provider is not necessary for each absence.

3. A serious health condition, which continues over an extended period of time, that requires periodic visits to a health care provider, and may involve occasional episodes of incapacity (e.g., asthma, diabetes). A visit to a health care provider is not necessary for each absence.

4. A permanent or long-term condition for which treatment may not be effective (e.g., Alzheimer's, a severe stroke, terminal cancer). Only supervision by a health care provider if required, rather than active treatment.

5. Any absences to receive multiple treatments for restorative surgery or for a condition which would likely result in a period of incapacity of more than three days if not treated (e.g., chemotherapy or radiation treatments for cancer).