

SECTION III (FOR COMPLETION BY HEALTH CARE PROVIDER – PLEASE PRINT):

INSTRUCTIONS to the HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," own," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Page 4 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: _____

Type of practice / medical specialty: _____

Telephone: (____) _____ Fax: (____) _____

PART A: MEDICAL FACTS – PLEASE PRINT:

Does the condition qualify under the definition of a “Serious Health Condition” (See last page of form)?

___ Yes (Complete this section of the form in its entirety)

___ No (Sign and date form on page 4)

1. Approximate date condition commenced: _____

Probable duration of condition: _____

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ___No ___ Yes. If yes, dates of admission: _____

Date(s) you treated the patient for condition: _____

Was medication, other than over-the-counter medication, prescribed? ___No ___ Yes.

Will the patient need to have treatment visits at least twice per year due to the condition?

___No ___ Yes.

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? ___No ___ Yes. If yes, state the nature of such treatments and expected duration of treatment:

2. Is the medical condition pregnancy? ___No ___ Yes. If yes, expected delivery date:

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

Part B: AMOUNT OF CARE NEEDED – PLEASE PRINT

When answering these questions, keep in mind that your patient’s need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ___No ___Yes.

Estimate the beginning and ending dates for the period of incapacity: _____

During this time, will the patient need care? ___No ___Yes.

Explain the care needed by the patient and why such care is medically necessary:

5. Will the patient require follow-up treatments, including any time for recovery?

___No ___Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Explain the care needed by the patient, and why such care is medically necessary:

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? ___ No ___Yes.

Estimate the hours the patient needs care on an intermittent basis, if any: _____hour(s)

per day; _____ days per week from _____ through _____

Explain the care needed by the patient, and why such care is medically necessary:

DEFINITION OF SERIOUS HEALTH CONDITION

“**Serious health condition**” means an illness, injury, impairment, or physical or mental condition that involves either:

- Inpatient care (*i.e.*, an overnight stay) in a hospital, hospice, or residential medical-care facility, including any period of incapacity (*i.e.*, inability to work, attend school, or perform other regular daily activities) or subsequent treatment in connection with such inpatient care; **or**
- Continuing treatment by a health care provider, which includes:

(1) A period of incapacity lasting more than three consecutive, full calendar 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 (*i.e.*, in-person visits, the first within 7 days and both within 30 days of the first day of incapacity); **or**
- one treatment by a health care provider (*i.e.*, an in-person visit within 7 days of the first day of incapacity) with a continuing regimen of treatment (*e.g.*, prescription medication, physical therapy); **or**

(2) Any period of incapacity related to pregnancy or for prenatal care. A visit to the health care provider is not necessary for each absence; **or**

(3) Any period of incapacity or treatment for a chronic serious health condition which continues over an extended period of time, requires periodic visits (at least twice a year) to a health care provider, and may involve occasional episodes of incapacity. A visit to a health care provider is not necessary for each absence; **or**

(4) A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective. Only supervision by a health care provider is required, rather than active treatment; **or**

(5) Any absences to receive multiple treatments for restorative surgery or for a condition that would likely result in a period of incapacity of more than three days if not treated.

For more information, including use of leave and substituting paid leave for unpaid leave, please see the Employee/Employer Rights, Responsibilities, and Definitions (http://www.co.henrico.va.us/hr/emprel/fmla_factsheet.pdf) at the Employee Relations FMLA Web page (<http://www.co.henrico.va.us/hr/benefits/fmla.html>).