

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



The University System of Georgia

FMLA

Medical Certification

Date

To be completed by the employee

•• Employee should also complete the name and address information at the bottom of page 2.

Employee's name: _____

Patient's name _____ Relationship to employee: Self Spouse Child Parent

If the patient is 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 taken intermittently or if it will be necessary for you to work less than a full schedule:

Employee signature Date

Patient name (if other than employee) **PRINT NAME** Patient signature (if other than employee) authorizing release of this information to the University System of Georgia Date

To be completed by the health care provider

(Health care provider for either the employee or the family member as described above.)

- Page 3 of this document describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Under which category of **Serious Health Condition** ¹ does the patient's condition qualify?
 1 2 3 4 5 6 None as described on page 3
- 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:
- State the approximate date the condition commenced _____
The probable duration of the condition _____
The probable duration of the patient's present incapacity ² (if different): _____
 - 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 for treatment described in item 6 below)? Yes No
If yes, give the probable duration: _____
 - If the condition is a chronic condition (p.3, #4) or a pregnancy (p.3, #3), state whether the patient is presently incapacitated.²
 Yes
 No

What is the likely duration and frequency of episodes of incapacity ²? _____

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

If the patient will be absent from work or other daily activities because of treatment on an intermittent or part-time basis, also provide an estimate of the probable number and interval between such treatments _____

Actual or estimated dates of treatment if known _____

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:

- 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):

Please complete question 5 if the patient is the employee or question 6 if the patient is a family member

5. a. 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 able to perform work of any kind? Yes
 No

- 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 (the employee or the employer should supply you with information about the essential job functions)?

Yes No

If yes, please list the essential functions the employee is unable to perform:

- c. If neither a. nor b. applies, is it necessary for the employee to be absent from work for treatment? Yes
 No

6. a. If leave is required to care for the employee's **family member** with a serious health condition, does the patient require assistance for basic medical or personal needs, or safety, or for transportation? Yes
 No

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

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

Name of health care provider

Signature of health care provider

Type of practice

Address

Telephone number

Please return this completed form to the employee, in person or to the following address:

Employee name

Employee address

A “**Serious Health Condition**” means an illness, injury impairment, or physical or mental condition that involves one of the following:

1. Hospital Care

Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity ² or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

a) A period of incapacity ² of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity ² relating to the same condition), that also involves:

- (1) **Treatment** ³ **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 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** ⁴ under the supervision of the health care provider.

3. Pregnancy

Any period of incapacity ² due to **pregnancy**, or for **prenatal care**.

4. Chronic Conditions Requiring Treatments

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 a health care provider;
- (2) Continues over **an extended period of time** (including recurring episodes of a single underlying condition); and
- (3) May cause **episodic** rather than a continuing period of incapacity ² (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-Term Conditions Requiring Supervision

A period of **incapacity** ² 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** ² **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), kidney disease (dialysis).

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 therefor, or recovery therefrom.

³ **Treatment** includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

⁴ **A regimen of continuing treatment** includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.