Mountain Grove R-III School District
Family and Medical Leave Act of 1993
CERTIFICATION OF HEALTH CARE PROVIDER

1. Employee's Name:

2. Patient's Name (if different from employee):

3. The attached sheet describes what is meant by a "**serious health condition**" under the Family and Medical Leave Act. Check the appropriate category under which the patient's condition[1] qualifies:
(1)____ (2)____ (3)____ (4)____ (5)____ (6)____ none of the above____

4. Describe the **medical facts** that support your certification, including a brief statement as to how the medical facts meet the criteria checked above:

5. a. State the approximate **date** the condition commenced and the probable duration of the condition (state the probable duration of the patient's present **incapacity**[2] if different):

   b. 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 the treatment described in #6 below)?
   ☐ yes ☐ no
   If yes, give the probable duration:

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

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

   b. 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, and period required for recovery, if any:

   c. If any of these treatments will be provided by **another provider or health service** (e.g., physical therapist) please state the nature of the treatments:

   d. **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)

[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 means the inability to work, attend school, or perform other regular daily activities due to the serious health condition, treatment for, or recovery from.

7. a. If a 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? ☐ 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 employer or employee should supply you with information about the essential job functions)? ☐ yes ☐ no
If yes, please list the essential job functions the employee is unable to perform:

c. If neither of the above applies, is it necessary for the employee to be **absent from work for treatment**?
☐ yes ☐ no

8. a. If leave is required for **care for an employee's family member** with a serious health condition, **does the patient require assistance** for basic medical or personal needs, 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, indicate the probable **duration** of this need:

Signature of Health Care Provider	Type of Practice
Address	Telephone Number
City, State, Zip Code	Date

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

Employee Signature	Date

SERIOUS HEALTH CONDITION

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 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:
   (a) treatment[3] two or more times by a health care provider, by a nurse of 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 that 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, or adoption, or foster care.

4. **Chronic Conditions Requiring Treatments**
   a chronic condition that:
   (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 incapacity2 (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 (e.g., 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 from) 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)

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[2]incapacity for purposes of FMLA means the inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment for, or recovery from

[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