



Route this form to:

Include, if needed, with Form UM 1516 sent to employee.

U Wide Form
UM 1515

Rev: 3/04

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

NOTE: Failure to fully complete this form could result in an initial denial of an FMLA leave or a delay in approval of an FMLA leave for the employee.

The information sought relates only to the condition for which the employee is taking FMLA leave. Complete this form, sign, and return to supervisor/responsible administrator. If the leave is 'foreseeable, a 30-day advance notice of the need for a leave is requested to the supervisor/responsible administrator along with the completed forms.

Employee's Name:

Patient's Name (if different from employee):

Does the patient's condition qualify under any of the following conditions (see "Definitions of Serious Health Condition", page 4):

Check off the 2nd box here.

- Hospital Care
- Absence Plus Treatment**
- Pregnancy or Prenatal Care
- Chronic Condition
- Permanent/Long-Term Condition Requiring Medical Supervision
- Multiple Treatments (non-chronic conditions)
- None of the above, specify:

Approximate date condition commenced:

Probable duration of condition:

Probable duration of patient's present incapacity¹ (if different from duration of condition):

Will it be necessary for employee to work intermittently or on less than a full schedule as a result of the condition?

If yes, give probable duration of need for intermittent or part-time work:

If the condition is a chronic condition or pregnancy, is the patient presently incapacitated?

Likely frequency of episodes of incapacity¹:

Likely duration of episodes of incapacity¹:

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 or on an intermittent or part-time basis, also provide (1) an estimate of the probable number and interval between such treatments; (2) actual or estimated dates of treatment if known; and (3) period required for recovery, if any:

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:

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

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):

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?

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)?

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

If neither of the above applies, is it necessary for the employee to be absent from work for treatment?

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?

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

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

Signature of Authorized Health Care Provider	Date
Type of Practice	Phone Number 612-626-6666
Address	

To be completed by the employee needing FMLA 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. Include 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's Signature your signature	Date
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DEFINITION OF 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 incapacity¹ or subsequent treatment in connection with or consequent to such inpatient care.
- 2. Absence Plus Treatment:** A period of incapacity¹ of more than three consecutive calendar days (including any subsequent treatment or period of incapacity¹ relating to the same condition), that also involves:
 - (a) Treatment² 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 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 which results in a regimen of continuing treatment³ under the supervision of the health care provider.
- 3. Pregnancy:** Any period of incapacity¹ due to pregnancy, or for prenatal care.
- 4. Chronic Conditions Requiring Treatments:** A chronic condition which:
 - (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 incapacity¹ (e.g., asthma, diabetes, epilepsy, etc.).
- 5. Permanent/Long-term Conditions Requiring Supervision:** A period of incapacity¹ 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 incapacity¹ 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), and kidney disease (dialysis).

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1. “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.
 2. 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.
 3. 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.