CERTIFICATION OF HEALTH CARE PROVIDER

INSTRUCTIONS: This form is to be completed by the patient's health care provider. All of the information sought on this form relates only to the condition for which the employee is seeking to take FMLA and/or state law leave, if applicable. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

Mail or fax completed forms to: Macalester College, Employment Services, 1600 Grand Avenue, St. Paul, MN 55015; **Fax: 651-696-6612**.

SECTION I: (completed by EMPLOYER):

Employer Name:	Macalester College	**Contact:**	Jason Dempster

SECTION II: (For Completion by the EMPLOYEE)

Please complete Section II before giving this form to your medical provider. The FMLA requires that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested, your response is required to obtain or retain the benefit of FMLA protections. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. You may have 15 calendar days to return this form.

Employee's Name: First Middle Last			
Employee's Job Title:		**Regular Work Schedule:**	
Employee's Essential Job Functions:			
☐ Check if job description is attached:			
Employee Signature:		**Date:**	

IF THE PATIENT IS *NOT* THE EMPLOYEE

Patient's Name: First Middle Last	
Patient's relationship to employee (e.g., husband, mother, child, etc.)**:**	
If child, what is the child's date of birth?	_____/_____/_____
Describe the care you will provide to your family member	
Describe the estimated leave need to provide care	

SECTION III: For Completion by the HEALTH CARE PROVIDER INSTRUCTIONS

Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. 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," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

HEALTHCARE PROVIDER INFORMATION

Printed name of health care provider:	
Signature of healthcare provider:	
Date of signature:	
Type of practice (including pertinent specialization, if any):	
Address:	
Telephone number:	
Fax number:	

CATEGORY OF SERIOUS HEALTH CONDITION:

Indicate which category of serious health condition applies to the patient **(see A-F on page 5)**:	☐A ☐B ☐C ☐D ☐E ☐F ☐ None
If "A" applies, has/will the condition involved inpatient care (i.e. an overnight stay) in a hospital, hospice, or residential medical care facility?	☐Yes ☐No
If "C" applies, provide delivery date:	☐Estimated ☐Actual: _____/_____/_____
If "F" applies, are treatments or restorative surgery after an accident or other injury? • If **no**, are there treatments for a condition that would likely result in a period of incapacity of more than 3 consecutive calendar days in the absence of such treatments? ☐Yes ☐No	☐Yes ☐No
Will the patient need to have treatment visits at least twice per year due to the condition? ☐Yes ☐No	
Describe the medical facts which demonstrate **how** the patient's condition meets the criteria of the category you have selected above as described on page 5:	

INFORMATION REGARDING THE PATIENT'S SERIOUS HEALTH CONDITION

Approximate date the **condition** began *and* its probable duration:
From _____/_____/_____ through _____/_____/_____

Probable duration of the patient's **incapacity** (inability to work, attend school or perform other regular daily activities) due to the condition (select one):

- ☐ From _____/_____/_____ through _____/_____/_____
- ☐ Same as duration of condition provided above
- ☐ Not applicable/No incapacity

Is a regimen of continuing treatment (e.g. prescription medication or therapy requiring special equipment) for the condition required? ☐Yes ☐No

If yes, provide a general description of the regimen:

Has the patient required previous treatment for this condition? ☐Yes ☐No

If yes, provide an estimate of the number of previous treatments: _____

Will the patient require additional treatment for this condition? ☐Yes ☐No

If yes, provide an estimate of the probable number of additional treatments: _____

If yes, will any of the additional treatments be provided by another health care provider? ☐Yes ☐No

If yes, describe the general nature of these treatments (e.g., physical therapy, etc.):

IF LEAVE IS RELATED TO PREGNANCY OR A CHRONIC CONDITION

(SEE ***C & D*** ON PAGE 5)

Is the patient currently incapacitated? ☐Yes ☐No

If **yes**, please provide the probably duration of the patient's present incapacity (select one):

- ☐ From _____/_____/_____ through _____/_____/_____
- ☐ Same as duration of condition provided above

Are **additional** periods of incapacity anticipated in connection with this condition? ☐Yes ☐No

If **yes**, how *often* are these additional periods expected to occur?
_____ times per ☐Week ☐Month ☐Year ☐Other (describe):

If **yes**, how *long* are these additional periods expected to last when they do occur?
_____ ☐Hours ☐Days ☐Weeks ☐Months ☐Other (describe):

ESSENTIAL JOB FUNCTIONS

Is the employee unable to perform any of his/her job functions due to the condition? ☐Yes ☐No

If so, identify the job functions the employee is unable to perform:

IF INTERMITTENT OR REDUCED LEAVE SCHEDULE IS NEEDED FOR TREATMENT

(INCLUDES PRENATAL CARE)

Probable interval between treatments: _____ times per ☐Week ☐Month ☐Year ☐Other (describe):

Period required for recovery from *each* treatment**:** _____ ☐Hours ☐Days ☐Weeks ☐Months ☐NONE ☐Other (describe):

THE EMPLOYEE'S LEAVE SCHEDULE

**Please provide the start and end dates requested below. "Unknown" or "indefinite" end dates may necessitate recertification after 30 days from the date of your signature on this certification or from the start date of the leave, whichever is greater.*

Is it necessary for the employee to be absent from work on a **full/continuous** basis? ☐Yes ☐No
If **yes**, please provide the beginning and end dates for the full/continuous leave:

From _____/_____/_____ through _____/_____/_____

Is it necessary for the employee to work a reduced schedule? ☐Yes ☐No
If **yes**, please provide the beginning and end dates for the reduced leave schedule:

From _____/_____/_____ through _____/_____/_____

Is it necessary for the employee to be absent from work intermittently? ☐Yes ☐No
If **yes**, please provide the beginning and end dates for the intermittent need for leave:

From _____/_____/_____ through _____/_____/_____

IF LEAVE IS NEEDED TO CARE FOR AN ILL FAMILY MEMBER

Does the patient require assistance for basic medical or personal needs or safety, or for transportation?
☐Yes ☐No

Will the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? ☐Yes ☐No

Will this assistance or care be needed on a continuous or intermittent leave basis?
☐Continuous ☐Intermittent

IF LEAVE IS NEEDED TO CARE FOR A CHILD AGE 18 OR OLDER

(SEE PAGE 5 FOR DEFINITION OF CHILD)

Does the child have a physical or mental impairment that substantially limits one or more of the child's major life activities? ☐Yes ☐No

If **yes**, what is the *probably* duration of this impairment? (select one) ☐Less than 1 year ☐ 1 year or more

If yes to the previous question, list the major life activities affected here and describe how they are substantially limited (see page 5 for examples):

_____

Does the child need assistance or supervision with three or more activities of daily living or instrumental activities of daily living? ☐Yes ☐No

If yes in the previous question, list at least three of those activities here: (see page 5 for examples):
(1)_____ (2)_____ (3)_____

SERIOUS HEALTH CONDITION CATEGORIES – A "Serious Health Condition" under FMLA means an illness, injury, impairment, or physical or mental condition that involves one of the following:

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

B. **Absence Plus Treatment**: A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition) that also involves:
   - Treatments 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 order of, or on referral by, a health care provider; or
   - Treatments by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.

C. **Pregnancy:** Any period of incapacity due to pregnancy or the prenatal care.

D. **Chronic Conditions Requiring Treatments**: A chronic condition which:
   - Requires periodic visits for treatment by a health care provider or by a nurse of physician's assistant under direct supervision of a health care provider; and
   - Continues over an extended period of time (including recurring episodes of a single underlying condition); and
   - May cause episodic rather than a continuing period of incapacity (e.g. asthma, diabetes, epilepsy, etc.)

E. **Permanent/Long-term Conditions Requiring Supervision**: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective (e.g. Alzheimer's, a severe stroke, or the terminal stages of a disease). The patient must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider.

F. F. **Multiple Treatments (Non-Chronic Conditions)**: Any period of absence to receive multiple treatments (including any period of recovery) by a health care provider or by a provider of health care services under order of, or on referral by, a health care provider, either for:
   - Restorative surgery after an accident or other injury, or
   - A condition that would likely result in a period of incapacity or 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).

OTHER TERMS AND DEFINITIONS

1. **Health Care Provider**: (a) The Act defines "health care provider" as (1) A doctor of medicine or osteopathy who is authorized to practice medicine or surgery (as appropriate) by the State in which the doctor practices; or (2) Any other period determined by the Secretary to be capable or providing health care services (b) Others "capable or providing health care services" include only: (1) Podiatrists, dentists, clinical psychologists, optometrists, and chiropractors (limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist) authorized to practice in the State and performing within the scope of their practice as defined under State law; (2) Nurse practitioners, nurse-mid-wives and clinical social workers who are authorized to practice under State law and who are performing within the scope of their practice as defined under State law; (3) Christian Science practitioner listed with the First Church of Christ, Scientist in Boston, Massachusetts; Where an employer that the employee or family member submit to examination (though not treatment) to obtain a second or their certification from a health agreement. (4) Any health care provider from whom and employer or the employer's group health plan's benefits manager will accept certification or the existence of a serious health condition to substantiate a claim for benefits; and (5) a health care provider listed above who practices in a country other than the United States, which is authorized to practice in accordance with the law of that country, and who is performing with the scope of his or her practice as defined under such paw; (c) the phrase "authorized to practice in the State" as used in this section means that the provider must be authorized to diagnose and treat physical or mental health conditions without supervision by a doctor or other health care provider.
2. **Incapacity**: The inability to work, attend school or perform other regular activities due to the patient's serious health condition, treatment for that condition, or recovery from that condition.
3. **Regimen of Continuing Treatment**: Treatment including, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to reserve or alleviate the health condition. A regiment of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves, nor does it include bed-rest, drinking fluids, exercise, or other similar activities that can be initiated with a visit to a health care provider.
4. **Treatment**: Includes examinations to determine if a serious health condition exists and evaluations of that condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.
5. **Intermittent Leave**: Leave that is taken periodically and may consist of separate click of leave for single serious health condition. Intermittent leave may vary in length from less than one hour to blocks lasting several weeks. Intermittent leave requests with undefined or unknown end dates may only be certified for periods of 30-90 days from the date of the health care provider's signature or start date of the leave, which ever is later.
6. **Reduced Schedule Leave**: Leave that either reduces the usual number of hours an employee works per day or weekly or changes an employee's schedule from full-time to part-time.
7. **Child**: A child is a son or daughter who is biological, adopted, or a foster child, stepchild, a legal ward, or a child for whom the employee has day-to-day responsibilities to care for and financially support. For FMLA purposes, a child must be (a) under age 18 or (b) age 18 or older and incapable of self-care because of a physical or mental disability which substantially limits one or more major life activities.
8. **Major Life Activities**: Caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working.
9. **Activities of Daily Living or Instrumental Activities or Daily Living**: Self-grooming and hygiene, bathing, dressing, eating, cooking, cleaning, shopping, using public transportation, paying bills, maintaining a residence, using telephones and directions, using the post office, etc.