CERTIFICATION BY EMPLOYEE'S HEALTH CARE PROVIDER FOR EMPLOYEE'S SERIOUS ILLNESS - FMLA

This form is to be completed by employee's Health Care Provider when employee is requesting FMLA and medical **documentation** is required *pursuant to 512.41, 513.36 and 515.5* of the *ELM.* ***Form PS 3971 must*** **be** ***completed*** *by employee.*

Employee's name:

Description of **serious health condition** (On the *back of this form is the description of a 'serious health condition" under FMLA. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category. In all instances the information on the form must relate only to the serious health condition for which the current need for leave exists.*

(1) (2) (3) (4) (5) (6) None of the above

Describe the medical facts **and/or treatment that meet the criteria** of the serious health **condition** checked **above (Medical diagnosis/prognosis is not required):**

Date condition commenced:

Probable duration of condition:

Probable duration of present Incapacity (if different):

Will the employee require leave on an intermittent or reduced schedule basis for planned medical treatment (e.g. follow-up Treatment) of the employee's serious health condition, including pregnancy? Yes No

If so, please provide an estimate of the dates and duration of such treatment and any period (s) of recovery:
Dates:

Duration: hour(s) or, day(s) per episode.

Period of Recovery:

Will the employee require leave on an intermittent or reduced schedule basis for the employee's serious health condition, Including pregnancy, that may result in unforeseeable episodes of incapacity (e.g. flare ups)? Yes No

If so, please provide an estimate of the frequency and duration of such episodes of Incapacity (e.g. 3 times per 1 month lasting 1-2 days):

Frequency: times per week(s) month(s):

Duration: hour(s) or day(s) per episode.

Is the employee able to perform the essential functions of employee's position?

If no, describe the physical
Restrictions placed on the employee, Including the duration of such restrictions.

Health Care Provider's Name (Please print):

Health Care Provider's Signature: **Date:**

Address:

Phone number: **Fax number:**

Specialty/Type of Practice: Family Practice