

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 : **John Doe**

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):

Male reproductive disorder that causes pulsating or throbbing pain, tenderness in pelvic area, fatigue, swelling and bleeding that will incapacitate the patient on an intermittent basis.

Date condition commenced: **9-5-09**

Probable duration of condition: **Lifetime**

Probable duration of present Incapacity (if different): **give date the employee was absence from work include sdo if in conjunction**

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: **if employee has appointment list it**

Duration: **hour(s) or, 1 to 2 day(s) per episode.**

Period of Recovery: **To be re-evaluated in 12 months.**

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: **1 to 2** times per **week(s)** **1** month(s):

Duration: **hour(s) or 1 to 2 day(s) per episode.**

Is the employee able to perform the essential functions of employee's position? Yes No, describe the physical restrictions placed on the employee, including the duration of such restrictions.

Health Care Provider's Name (Please print): **Dr. John Well**

Health Care Provider's Signature:

Date:

Address:

Phone number:

Fax number:

Specialty/Type of Practice: **Family Practice** **May Provide Business Card**