Sauk Prairie Healthcare
Health Care Provider Certification

SECTION I – TO BE COMPLETED BY EMPLOYEE

Instructions to the Employee: Please complete this section before giving this form to your medical provider.

1. **Name of Employee:**	2. **Name of Patient:**	2b. **Relationship of Patient to Employee:** ☐ Self ☐ Parent ☐ Spouse ☐ Dependent Child _____ (Age of Child)
Employee's Department:	Employee's Supervisor:	

SECTION II – TO BE COMPLETED BY MEDICAL PROFESSIONAL ONLY

Instructions to the Health Care Provider: Your patient has requested leave under the FMLA, or the employee listed above has requested leave under the FMLA to care for your patient. Several questions seek a response 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. You also may, but are not required to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

3. **Select appropriate level category** (definitions on back):	4. **Medical Facts related to conditions requiring leave:**
☐ Inpatient Care ☐ Incapacity plus Treatment (e.g. outpatient surgery) ☐ Pregnancy – Expected **Due Date:** _____ ☐ Chronic Condition(s) (e.g. asthma, migraines) ☐ Permanent/Long-term Conditions (e.g. Alzheimers) ☐ Multiple Treatments (e.g. chemotherapy) ☐ None of the above	
5a. **Onset and duration of condition:**	5b. Date(s) of patient's **present incapacity** (if different from 5a):

6. **Please indicate type of leave requested:**

☐ **Continuous:**

Give duration of time off work:

Total number of: _____ day(s) **OR** _____ week(s) **Begin date:** _____ **End Date:** _____.
(circle either days or weeks)

☐ **Intermittent:** Please estimate episodic leave based upon patient's past history.

Give frequency and duration of illness episodes:

Total number of: _____ hour(s) **OR** _____ day(s) **Per** ☐ day ☐ week ☐ month ☐ year **Begin date:** _____ **End date:** _____.
(circle either hours or days, then indicate whether per day/week/month/year)

7. **Prescribed treatment regimen and schedule:**

☐ Office visits: #_____ per ☐ day ☐ week ☐ month ☐ year ☐ Surgery (date): _____

☐ Therapy visits: #_____ per ☐ day ☐ week ☐ month ☐ year ☐ Procedure (type/date): _____

☐ Prescription medication: _____ ☐ Other treatments (type/dates): _____

☐ Referral to other providers (who):

Complete only if certification is for: Employee's Own Serious Health Condition:

8. Is in-patient hospitalization of the employee required? ☐ No ☐ Yes (give dates): _____	9. Is employee able to perform work of any kind? ☐ No ☐ Yes

10. **Is employee able to perform the funtions of the employee's position during incapacity?** ☐ No ☐ Yes

10b. **If not,** please describe employee's restrictions and their duration:

Restrictions **(If applicable, include need for reduced work schedule)**: _____

Complete only if certification is for: Family Member's Serious Health Condition:

11. Will the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation? ☐ No ☐ Yes

12. Is the employee's presence necessary or would it be beneficial for the care of the patient? (This may include psychological comfort). ☐ No ☐ Yes

If YES, provide detail(s): _____

13. Estimate the period of time care is needed under 11 or 12 above?

_____ _____

Health Care Provider Signature **Date Signed**

Print name of Health Care Provider:	Address of Health Care Provider:
Type of practice (Field of specialization, if any):	Office Telephone #:

SECTION III – TO BE COMPLETED BY EMPLOYEE

Instructions for the Employee: Please complete this section before returning the form to Human Resources.

14. **To be completed by the Employee Needing Leave for a Family Member's Serious Health Condition**
State the care you will provide and an estimate of the time period during which this care will be provided, including a schedule if leave is to be taken intermittently or on a reduced leave schedule:

_____ (_____)_____ (_____)_____ _____

Employee Signature **Work Number** **Home Number** **Date**

Please return form by email to hr@saukprairiehealthcare.org.

Address: 90 Oak Street, Prairie du Sac, WI 53578 Phone: (608)643-7163

A "**Serious Health Condition**" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. Inpatient Care
   Inpatient care means an overnight stay in a hospital, hospice, or residential medical care facility, including any period of incapacity[1] or any subsequent treatment in connection with such inpatient care.
2. Incapacity and treatment
   A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves:
   a) Treatment[2] two or more times, within 30 days of the first day of incapacity, unless extenuating circumstances exist, by a health care provider, by a nurse 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 treatment under the supervision of the health care provider.
   c) The requirement in paragraphs (2) (a) and (b) or this section for treatment by a health care provider means an in-person visit to a health care provider. The first (or only) in-person treatment visit must take place within seven days of the first day of incapacity.
   d) Whether additional treatment visits or a regimen of continuing treatment is necessary within the 30-day period shall be determined by the health care provider.
   e) The term "extenuating circumstances" in paragraph (2) (a) of this section means circumstances beyond the employee's control that prevent the follow-up visit from occurring as planned by the health care provider. Whether a given set of circumstances are extenuating depends on the facts. For example, extenuating circumstances exist if a health care provider determines that a second in-person visit is needed within the 30-day period, but the health care provider does not have any available appointments during that time period.
3. Pregnancy or prenatal care
   Any period of incapacity due to pregnancy, or for prenatal care.
4. Chronic Conditions
   Any period of incapacity or treatment for such incapacity due to a chronic serious health condition. A chronic serious health condition is one which:
   a) Requires periodic visits (defined as at least twice a year) for treatment by a health care provider, or by a nurse under direct supervision of a health care provider;
   b) Continues over extended period of time (including recurring episodes of a single underlying condition); and
   c) May cause episodic rather than a continuing period of incapacity (*e.g.,* asthma, diabetes, epilepsy, etc.).
5. Permanent/Long-term Conditions
   A period of incapacity 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.
6. Conditions Requiring Multiple Treatments
   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, for:
   a) Restorative surgery after an accident or other injury; or
   b) A condition that would likely result in a period of incapacity of more than three consecutive, full calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), or kidney disease (dialysis).

[1] The term "incapacity" means inability to work attend school or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery therefrom.

[2] The term "treatment" includes (but is not limited to) examinations to determine if a serious health condition exists and evaluations of a condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations. 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 (e.g. oxygen). A regimen of continuing treatment that includes 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, is not, by itself, sufficient to constitute a regimen of continuing treatment for purposes of FMLA leave.