VA MEDICAL CENTER MEMORANDUM. 05-13-03
ATTACHMENT "C"

Certification of Physician or Practitioner for FMLA Leave

1. Employee's name: _____

2. Patient's name (if other than employee): _____

3. Diagnosis: _____

4. Date condition commenced: _____ (***must be completed***)

5. Probable duration of condition: _____ (***must be completed***)

NOTE: If the FMLA leave requested is **intermittent**, the health care provider must provide anticipated frequency and duration for FMLA absences per 5 CFR 630.1208(b) (2). If intermittent, please answer the questions below.

a. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? ____◯____ NO ____◯____ YES

b. Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of the flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g. 1 episode every 3 months lasting 1-2 days):

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

Duration: _____ hours or _____ day(s) per episode

c. Does the patient need care during these flare-ups? _____ NO _____ YES

d. Explain the care needed by the patient, and why such care is medically necessary:

6. Regimen of treatment to be prescribed (indicate referral to other provider of health services)

a. By physician or practitioner: _____

b. By another provider of health services, if referred by physician or practitioner: _____

IF THIS CERTIFICATION RELATES TO CARE FOR THE EMPLOYEE'S SERIOUSLY ILL FAMILY MEMBER, SKIP ITEMS 7, 8, AND 9 AND PROCEED TO ITEMS 10 THRU 14. OTHERWISE, CONTINUE BELOW.
CHECK Yes or No in the boxes below, as appropriate.

7. Yes ◯ No ◯ Is inpatient hospitalization of the employee required?

8. Yes ◯ No ◯ Is employee able to perform work of any kind? (If "no," skip item nine.)

9. Yes ◯ No ◯ Is employee able to perform the functions of employee's position? (Answer after reviewing statement from employer of essential functions of employee's position, or, if none provided, after discussing with employee.)

FOR CERTIFICATION RELATING TO CARE FOR THE EMPLOYEE'S SERIOUSLY ILL FAMILY MEMBER, COMPLETE ITEMS **10 THROUGH 14 BELOW AS THEY APPLY TO THE FAMILY MEMBER** AND PROCEED TO ITEM 15.

10. Yes ◯ No ◯ Is inpatient hospitalization for the family member (patient) required?

11. Yes ◯ No ◯ Does (or will) the patient require assistance for basic medical, hygiene, nutritional needs, safety or transportation?

12. Yes ◉ No ◯ After review of the employee's signed statement (see item 14 below), is the employee's presence necessary or would it be beneficial for the care of the patient? (This may include psychological comfort.)

13. Estimate the period of time care is needed or the employee's presence would be beneficial:

ITEM 14 IS TO BE COMPLETED BY THE EMPLOYEE NEEDING **FAMILY LEAVE**.

14. When family leave is needed to care for a seriously ill family member, the employee shall state the care he or she 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: _____
Date: _____

15. Signature of physician or practitioner:

_____

_____
P**rovider's printed name**

16. Date: _____

17. Type of practice (field of specialization, if any):

_____

18. Phone number to contact provider:

_____