

ATLANTIC COUNTY MEDICAL CERTIFICATION FORM
CERTIFICATION OF HEALTH CARE PROVIDER

For purposes of completing this form please note the following:

Here and elsewhere on this form the information sought relates only to the condition for which the employee is taking FMLA leave.

"Incapacity," for the purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefore or recovery therefrom.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting genetic information of an individual or family member of the individual, except as specifically allowed by law. To comply with this law, we are asking that you not provide any genetic information when responding to this request medical information. 'Genetic Information' as defined by GINA, includes family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo held by an individual or family member receiving reproductive services.

1. Employee's Name: _____

2. Patient's Name (if different from employee): _____

3. Page four describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition qualify under any of the categories described? If so, please check the applicable category.

Inpatient Care Incapacity and treatment Pregnancy Chronic Condition

Permanent or Long term Condition Condition requiring multiple treatments None of the above

4. Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

5.a. State the approximate date the condition commenced, and the probable duration of the condition (and also the probable duration of the patient's present incapacity if different):

Condition Commenced _____

Probable Duration _____

Incapacitated From: _____ To: _____
month/day/year month/day/year

5.b. Will it be necessary for the employee to take work only intermittently or to work on a less than full schedule as a result of the condition (including the treatment described in Item 6 below?)

If yes, give the probable duration:

5.c. If the condition is a chronic condition (condition #4) or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity .

ATLANTIC COUNTY MEDICAL CERTIFICATION FORM
CERTIFICATION OF HEALTH CARE PROVIDER

6.a. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments:

If the patient will be absent from work or other daily activities because of treatment on an intermittent or part-time basis, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

6.b. If any of these treatments will be provided by another provider of health services, e.g., physical therapist, please state the nature of the treatments:

6.c. If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of a such regimen, e.g., prescription drugs, physical therapy requiring special equipment:

7.a. If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee unable to perform work of any kind? Yes _____ No _____

7.b. If able to perform some work, is the employee unable to perform any one or more of the essential functions of the employee's job (the employee or the employer should supply you with information about the essential job functions)? Yes _____ No _____ If yes, please list the essential functions the employee is unable to perform:

ATLANTIC COUNTY MEDICAL CERTIFICATION FORM
CERTIFICATION OF HEALTH CARE PROVIDER

- 8.a. If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation?
Yes _____ No _____
- 8.b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery? Yes _____ No _____
- 8.c. If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need:

(Signature of Health Care Provider)

(Type of Practice)

(Name of Health Care Provider, Please Print)

(Date)

(Street Address)

(City, State, Zip)

(Telephone Number)

To be completed by the employee needing family leave to care for a family member:

State the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

(Employee Signature)

(Date)

ATLANTIC COUNTY MEDICAL CERTIFICATION FORM
CERTIFICATION OF HEALTH CARE PROVIDER

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

1. Hospital Care

Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity² or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

(a) A period of incapacity² of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity² relating to the same condition), that also involves:

(1) **Treatment**³ **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 orders of, or on referral by, a health care provider; or

(2) **Treatment** by a health care provider on **at least one occasion** which results in a **regimen of continuing treatment**⁴ under the supervision of the health care provider.

3. Pregnancy

Any period of incapacity due to **pregnancy**, or for **prenatal care**.

4. Chronic Conditions Requiring Treatments

A **chronic condition** which:

(1) Requires **periodic visits** for treatment by a health care provider, or by a nurse or physician’s assistant under direct supervision of a health care provider;

(2) Continues over an **extended period of time** (including recurring episodes of a single underlying condition); and

(3) May cause **episodic** rather than a continuing period of incapacity² (e.g., asthma, diabetes, epilepsy, etc.).

5. Permanent/Long-term Conditions Requiring Supervision

A period of **Incapacity**² 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**. Examples include Alzheimer’s, a severe stroke, or the terminal stages of a disease.

6. Multiple Treatments (Non-Chronic Conditions)

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, either for **restorative surgery** after an accident or other injury, **or** for a condition that **would likely result in a period of Incapacity² of more than three consecutive calendar days in the absence of medical intervention or treatment**, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), and kidney disease (dialysis).

³Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

⁴ 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. A regimen of treatment does not include 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.