Employee Health Certification Form

*This form is used (1) to determine whether an employee's condition qualifies as a "serious health condition" under the **Family and Medical Leave Act (FMLA**) and for administration of Dow's FMLA policy, and (2) to obtain information regarding an employee's eligibility and administration of the requirements of Dow's **Paid Medical Leave Policy***

1. Employee Information (To be completed by Employee) *Note: If employee is unable to initiate, supervisor may complete part 1.*

Employee Name: _____ **Employee User ID**: _____ **DOB:** _____

Department: _____ **Location:** _____ **Leader:** _____

HR Contact: _____ **Work Phone:** _____ **Home/cell Phone:** _____

2. Absence/Illness Information & Release (To be completed by Employee)

First Date Missed Work_____ Anticipated Return to Work Date (if known): _____Illness/Injury Began On _____

Medical Condition: Was your injury/illness related to work? ☐ No ☐ Yes (*If yes, please contact Health Services to complete an Injury/Illness Report))*

I authorize my health care provider to release information requested by Dow to administer this medical leave. I certify the information I have provided is correct to the best of my knowledge.

Signature_____ **Date** _____

3. To be completed by employee's Health Care Provider.

Provider Instructions: Please fill in the appropriate response and return to Dow Health Services (see fax/address below).

Medical Condition (*diagnosis, surgery type*): _____

Anticipated duration of incapacity and applicable restrictions:

☐ Unable to return to work indefinitely ☐ Currently unable to perform work of any kind

Able to return to: ☐ **REGULAR** Work ***(no restrictions) ON***__/__/__ ☐ **RESTRICTED** Work **(*Please describe below)* ON**:__/___/__

Activity Limitation: (*Please check all that apply*) **Probable duration of limitation** _____***(date)***

☐ Not to work more than _____hours per day	☐ No upper extremity repetitive motion: __ Rt. __Left
☐ No standing ☐ Limited standing	☐ Limited upper extremity repetitive motion: __ Rt. __Left
☐ No walking ☐ Limited walking	☐ No bending/turning of head/neck ☐ Limited bending/turning of head/neck
☐ No stair climbing ☐ Limited stair climbing	☐ No Work on ladders, scaffold or at unprotected heights
☐ No lifting, pushing or pulling over ___ lbs.	☐ Limited Work on ladders, scaffold or at unprotected heights
☐ No continuous heavy physical exertion	☐ No overhead work with arms ☐ limited overhead work with arms
☐ No operating hazardous/fast moving machinery	☐ No bending, twisting, stooping at waist
☐ No kneeling/squatting	☐ Limited bending, twisting, stooping at waist
☐ No overhead Work with Arms	☐ No driving a vehicle, including a fork lift
☐ Limited Overhead Work with Arms	☐ Limited Operating a vehicle, including a fork lift ____hours per shift

Other Restrictions/Accommodations_____

_____

Does the patient's condition qualify as a "*serious health condition"* under the FMLA? If so, please check categories below? *(see reference on the next page)* ☐ 1. Inpatient Care ☐ 2. Incapacity Plus Treatment ☐ 3. Pregnancy /Prenatal Care ☐ 4.Chronic Condition ☐ 5. Permanent or Long-term Condition ☐ 6. Condition Requiring Multiple Treatments ☐ 7. Absences Attributed to Incapacity ☐ 8. Does not Qualify

If the condition is a **chronic** (condition #4) or **pregnancy**, what is the likely duration and frequency of episodes of incapacity?_____

Health Care Provider (*Please Print Name) :* _____***(Signature)* :** _____

Address: _____**Telephone:** _____ **Date:** _____

Please fax or mail this form to Dow's Occupational Health Facility listed below or give to the employee for return to:

Dow Health Services Name: (Insert Name) ***Health Services – Attention (Insert Contact) Phone/Fax (Insert phone) Fax: (Insert Fax)***

Address: ***(Insert Address)***_____

Employee Health Certification Form

This form should be completed by the employee and the employee's health care provider and returned in a timely manner to the site Dow Health Services contact in any situation in which an employee:

- Needs to be off work or is estimated to miss work for 80 or more consecutive work hours for the employee's own medical condition
- Requests FMLA leave, even if the absence is not estimated to be 80 hours or more
- Request intermittent medical leave or an otherwise reduced schedule for more than two consecutive work weeks
- Requests Parenting (Maternity) Leave

This form is used

- To determine whether an employee's condition qualifies as a "serious health condition" under the Family and Medical Leave Act (FMLA) and for administration of Dow's FMLA policy, and to obtain information regarding an employee's eligibility and administration of the requirements of Dow's Paid Medical Leave policy.

***Note**: There may be additional or different requirements based on site contractual agreements or policies. A new form should be completed for each condition/absence or for any additional time for the same condition after the employee has returned to work without restrictions.*

***Note: The Health Care Provider will NEED the following* SERIOUS HEALTH CONDITION DESCRIPTION – FMLA**

A "Serious Health Condition" means an illness, 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] as defined in, or any subsequent treatment in connection with such inpatient care.
2. Incapacity and Treatment
   a) A period of incapacity[1] of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves:
   (1) 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 treatment by a health care provider on at least one occasion, which results in a regimen of continuing treatment[3] under the supervision of the health care provider.
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:
   (1) 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
   (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 incapacity (1) (e.g., asthma, diabetes, epilepsy, etc.).
5. Permanent or long-term Conditions
   A period of incapacity [1] 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. 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:
   - Restorative surgery after an accident or other injury; or a condition that would likely result in a period of incapacity*(2)* 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).
7. Absences attributable to incapacity
   Pregnancy (3) or chronic condition(4) *(of this section)* qualify for FMLA leave even though the employee or the covered family member does not receive treatment from a health care provider during the absence, and even if the absence does not last more than three consecutive, full calendar days. For example, an employee with asthma may be unable to report for work due to the onset of an asthma attack or because the employee's health care provider has advised the employee to stay home when the pollen count exceeds a certain level. An employee who is pregnant may be unable to report to work because of severe morning sickness.

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[1] *"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] *"treatment" includes (but is not limited to) 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.*
[3] *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.*

Document Control and History

Translated Versions Available

None

Document History

The following table contains the creation history:

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6/29/11	M Katt	Clinical Services	Review only
5/6/15	Eileen Bonner	US RHD	Updated footer and added a document control and history
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Location of document

This document is located at: \\usnt45\EHSGLOBALTM2-Public\ReadOnly\Health Services\US_OD\Health Care\Case Management

This document also resides on the myHR webpage (Benefits/Time off work/Leaves of Absence/FMLA/Resources)